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White Paper:

**Potential of Expanding the
Denali Commission Primary Care Program
To Other Types of Health Care Facilities**

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INTRODUCTION AND RECOMMENDATIONS

The purpose of the Denali Commission is to work in collaboration with the governments and people of Alaska to develop diversified and sustainable communities supported by a fully developed and well-maintained infrastructure. The values that support and guide the work of the Commission are:

- **Catalyst for Positive Change** – The Commission will be an organization through which agencies of government, including tribal governments, may collaborate, guided by the people of Alaska, to aggressively do the right thing in the right ways.
- **Respect for people and Cultures** – the Commission will be guided by the people of Alaska in seeking to preserve the principles of self-determination, respect for diversity, and consideration of the rights of individuals.
- **Inclusiveness** – The Commission will provide the opportunity for all interested parties to participate in decision making and carefully reflect their input in the design, selection and implementation of programs and projects.
- **Sustainability** – The Commission will promote programs and projects that meet the current needs communities and provide for the anticipated needs of future generations.
- **Accountability** – the Commission will set measurable standards of effectiveness and efficiency for both internal and external activities.

The Denali Commission Act of 1998 was amended in 1999 to provide support for the planning, construction, and equipping of demonstration health, nutrition and childcare projects including

- Hospitals
- Health clinics
- Mental health facilities
- Drug and alcohol treatment centers

In one of its first decisions, the Denali Commission designated rural primary health care facilities as a top priority. The Commission gave particular priority to primary care facilities in communities with a year-round population of more than 20 residents¹ and that did not have an inpatient facility.

¹ The Commission has a population study currently underway to re-evaluate the 20 person threshold for small villages.

To help assess the need and potential costs of primary care facilities across the state the commission established a Health Steering Committee. The Alaska Native Tribal Health Consortium (ANTHC) was recruited as a partner because of their extensive experience in construction of projects in rural communities. ANTHC also brought professional engineering and management capacity to help support the effort of the Commission.

Drawing on guidance from stakeholders and the public, the Health Steering Committee established several objectives for funding of primary care projects.

- Communities with the greatest need would be given a priority for funding *as long as they demonstrated the capacity to complete the facility and operate the program.*
- Clinics would be sized to appropriately serve the community.
- Multi-use facilities would be encouraged.

In October of 1999 the Denali Commission funded a project with the ANTHC to provide an assessment of the need for primary care facilities in the state. This study, *Alaska Rural Primary Care Facility Needs Assessment*, was completed in October 2000. The report reviewed health facilities in 288 rural communities that lacked hospital facilities and had year-round populations of greater than 20 people. It provided for the first time a comprehensive assessment of needs for primary care and estimated costs of providing facilities in these communities. In addition, the Needs Assessment provided for a priority assessment and ranking of the relative need of each community.

As a follow-up to the Needs Assessment the Denali Commission (through its program partner – the State of Alaska Department of Health and Social Services) contracted with Information Insights to review progress on funding the rural primary care clinics and to explore whether the Commission should begin to extend capital funding opportunities to other stand-alone, non-primary care health and human services facilities in rural communities. The contractors were charged with looking at the Commission's progress in funding primary care clinics, as well as exploring the need and advisability of expanding funding to non-primary care health and human services providers. This report provides overviews of current levels of service, funding mechanisms, and facility needs for hospitals, nursing homes, assisted living, mental health, substance abuse, early childhood programs (childcare and Head Start), domestic violence shelters and rural learning centers.

Findings

Since FY2001 the Denali Commission has been actively funding the design and construction of new primary care facilities in rural communities. This effort has focused on facilities in Level I and Level II communities (see appendices for definitions of level of community care). In the last two years the

Commission has approved over \$50 million in funds to support projects with a total cost of over \$100 million. Primary care projects currently approved in 87 different communities² include 52 construction projects, 26 design projects, and 36 planning and pre-design projects. In FY03 there are 38 projects in the planning or design phase that could be ready for FY03 construction awards.

It is clear that the Commission has been successful in developing primary care clinics in the high and middle priority communities that were included in the survey carried out through the Needs Assessment. A little over one third of the communities ranked in Groups 1-5 in the survey have received project funding. About a fourth the communities with middle rankings of Groups 6-10 have received project funding, as have approximately 10 percent of communities with ranking over Group 10. In total, almost one quarter of the communities surveyed in the Needs Assessment have received funding for planning, design or construction.

Finding: *Completing the funding of rural primary care clinics will likely take substantially more funding than estimated in the Alaska Rural Primary Care Needs Assessment due to increased demand for “large clinics” and expansion of functions from those originally envisioned for prototypical “small clinics.”*

Total costs for rural primary care infrastructure in the communities that were included in the Alaska Rural Primary Care Needs Assessment (October 2000) are likely to be substantially higher than the \$253 million dollars estimated in 2000. The principle causes for this increase are:

- Recent expansion of the medium and large prototype “small” clinic to include space for Dental care
- Recent expansion of the medium and large prototype “small” clinic to include space for Mental Health and Substance Abuse treatment.
- Significant increase in need for “large” clinic construction stimulated by explosive growth in Community Health Center projects over the past 3 years, and
- Normal inflationary construction cost increases

This report estimates total costs to fund the entire need defined in the Alaska Rural Primary Care Needs Assessment to be about \$481 million dollars. Estimates for the substantial increase in “large” clinic construction, however, rely on limited information and could be highly sensitive to continuing

² The majority of these projects are stand alone primary care clinics, a small number of projects however include additional ancillary health and social service functions and an even smaller minority that are multi-use facilities which include a broad array of public services.

expansion of the ongoing Community Health Center Funding provided under Section 330 of the Public Health Services Act.

The dollar amount of funding to complete the unmet need of primary care clinic replacement and renovation, however, will be substantially less than the total amount of need determined for all rural communities. Not all villages that have a need for a new or renovated primary care clinic will participate in Denali Commission projects due to local factors such as community desire for a clinic, capacity to carry out a project, or sustainability of a clinic.

In addition, the funds required by the Commission to support primary care will be reduced by the amount of the statutory match that is required of local communities. The total amount of match required will be about 35 percent³ of total project costs, which is the historical average match required for all clinic projects. The table below is an estimate of the total Denali Commission funding that will be required after the FY2003 funding cycle to fully fund primary care facilities in the rural areas of Alaska.

Estimate of Denali Commission Funding and Match Funds

	Total (millions)	Denali Funds (millions) 65%	Match Required 35%
Total Unmet Need	\$481	\$313	\$168
Demand Adjustment - 20% reduction	(\$96)	(\$63)	(\$34)
Funded in FY2001 and FY2002	(\$77)	(\$50)	(\$27)
Estimated Funding For FY2003	(\$54)	(\$35)	(\$19)
Total Remaining Unmet Need	\$254	\$165	\$89

Total costs to fund the expected demand for primary care infrastructure development after the FY2003 funding cycle are estimated at \$254 million dollars. At current match requirements, the match will be \$89 million dollars of that total, and the Denali Commission requirement will be \$165 million.

Finding: *Acquiring matching funds may be an issue in completing the replacement of village clinics, especially for small villages. Small villages normally do not have available discretionary cash reserves or discretionary income that would allow them to amortize a loan for a new facility. This problem for small villages could be reduced by increased planning with granting agencies and foundations and regional health corporations. In addition the proportionate increase in “large clinic” applicants will increase the availability of match as these applicants have increased debt capacity and/or cash reserves available for match.*

³ Current average match on approved Denali Commission projects when outliers such as Fireweed Clinic are excluded.

The Denali Commission staff is also concerned that the project applicants will have difficulty raising the matching funds. In FY2003 the clinic projects likely to move to the construction phase have a projected total cost of approximately \$38 million, with a required match of \$13.7 million⁴. Matching funds come from grants and from cash and loans from the recipient or regional tribal organization. Existing sources of capital grant funds appear to be adequate to sustain levels of contribution of between \$6.5 million to \$8.5 million per year and the remainder must be raised by the project applicants through loans or cash resources or with the support of regional organizations that provide the village services.

Accurate estimates of the amount of capital that applicants may have for match are difficult to obtain. Applicant contributions from cash reserves or loans will likely increase as more large clinics are approved and as smaller communities and regional corporations have time to plan for and incorporate the need for this capital into their long term fiscal plans.

Finding: *The longer schedule of 7 years to fund the total need for primary care clinic construction will reduce the annual matching requirement and facilitate the acquisition of matching funds by the grantees.*

Completing the primary care construction over the next seven years will require about \$13 million per year of matching funds. This appears to be feasible with current grant sources and private contributions at current levels. Acceleration of the complete funding cycle to five years will require an annual cash match of \$18 million, significantly increasing the difficulty of acquiring matching funds.

5 and 7-Year Cash Flow Estimates

	Total (Millions)	Denali Funds (Millions) 65%	Match Required 35%
Total Remaining Unmet Need	\$254	\$165	\$89
Annual Cash flow on 5 year schedule	\$ 51	\$ 33	\$18
Annual Cash flow on 7 year schedule	\$ 36	\$ 24	\$13

In addition to providing support for rural primary care facilities, the Denali Commission has supported and encouraged the development of multipurpose facilities which could include primary care in smaller communities. The health steering committee also recently expanded the scope of services to be provided through the primary care facilities; prototypes for new clinics now will include

⁴ Briefing paper Denali Commission – Estimated Cost Share Match for FY03 Clinic Projects, November 7, 2002.

space for non-medical health care services including dental care, and mental health and substance abuse counseling. The Commission however, has not routinely⁵ accepted applications for primary care facilities attached to hospitals or for other types of stand-alone health and human service facilities that may be needed in the rural communities to provide non-primary care services.

To explore the feasibility of extending Denali Commission funding to additional rural health services, the need for other types of facilities in rural communities was surveyed, including

- Primary care in rural hospitals
- Rural hospitals
- Nursing homes
- Assisted living facilities
- Stand alone mental health facilities
- Stand alone substance abuse treatment facilities
- Childcare and Head Start facilities
- Domestic violence shelters (*Rasmuson Foundation Survey*)
- Food banks and pantries
- Rural learning centers

Finding: Although some information on capital needs is available for most types of services, none of the health and human services (with the possible exception of Domestic Violence Shelters) surveyed for this report have conducted a statewide facilities needs assessment similar to the Alaska Primary Care Needs Assessment. The State of Alaska in conjunction with the Alaska Native Tribal Health Consortium is planning to complete a comprehensive plan of the Health Care Facilities in Alaska in the next two years.

The Rasmuson Foundation has completed a survey of capital needs of domestic violence shelters. This survey relies on the self-reported capital needs of the shelters. Contrasted to this approach was the Denali Commission's Alaska Rural Primary Care Facility Needs Assessment that carefully proscribes space standards for new facilities. This survey was followed up by a "code and condition" survey by teams of architects and engineers that documented the condition of the existing facilities in comparison to the standards identified in the assessment. Each type of survey has benefits and weaknesses. The self reported survey is relatively quick and will provide needed improvements to meet the immediate service delivery demands but may not adequately plan for future needs. The more comprehensive approach of the Rural Primary Care Needs Assessment is much more resource intensive but results in more equitable distribution of resources and more effective planning for future needs.

⁵ Two exceptions to this have been the Fireweed Clinic facility and some planning funds for the Griest Center in Barrow.

Almost all of the stakeholders and key informants contacted for this report expressed the need for additional investment capital to provide upgrades or construction of facilities and/or new technology and equipment. Most did not have detailed information on the specific projects or costs that were needed. Several programs had developed general priorities for investment and program development, but in most cases felt that needed projects would require additional development and detailed business plans to insure sustainability and most effective use of capital.

Hospitals were the notable exception to this trend. Most rural hospitals have ongoing capital planning processes that include periodic replacement and upgrade of capital equipment, enhancement and expansion of facilities, and in some cases complete facility replacement. Although it is difficult to determine the exact proportion of hospital capital projects that would be classed as “primary care,” the currently planned upgrades and replacements that are in Alaska hospitals’ master plans total in the hundreds of millions of dollars. Planning for most of these projects assumes funding from a combination of hospital cash reserves and debt. For the IHS/Tribal facilities, funding assumptions include cash and/or also direct federal appropriations from the IHS facilities accounts which are designated for maintenance and improvement of federally or tribally owned facilities, and in some cases new facility construction.

Finding: *For the majority of Alaska hospitals, participation of the Denali Commission in funding these projects will enhance and accelerate the ability of the hospital to invest in needed capital projects and may enable these facilities to add additional projects to the list, but it will not materially affect the long-term financial success of the hospital.*

For some Alaska hospitals, especially small, low volume, non IHS/tribal hospitals currently sustaining an operating loss, capital from the Denali Commission may enable these facilities to provide needed investment in critical capital projects that would otherwise be impossible. What impact this investment would have on the long-term sustainability of these facilities is impossible to predict.

Unlike the problems of finding support for small village clinic construction projects, the availability of matching funds is unlikely to pose a barrier for most of the hospital projects. The addition of Denali Commission or other resources to support capital projects on the list above would have the likely result of

- a) Accelerating construction of these projects, and
- b) Moving projects not in “high priority” status onto the list from the hospital master plan as additional resources become available for investment into these capital needs.

Finding: *Expanding the focus of the Denali Commission to funding other types of health and human service facilities would shift the focus of investment from Level I and II communities to larger Level III communities which could successfully sustain these services.*

In most cases it was apparent that additional investment in the expanded list of services listed above (with the possible exception of Head Start) would probably be concentrated in the larger Level III communities – those that currently have an inpatient facility and have been excluded from consideration in the Primary Care Clinic projects. These hub communities have substantial impact across their regions by providing key support in the operation and development of primary care and other health and human services in the Level I and II communities which are currently the focus of the Denali Commission priorities.

Finding: *Prioritizing between types of services to be supported with Denali Commission funds will be difficult.*

Although several program areas such as assisted living and domestic violence have developed clear priorities for program and/or facility development, there are few criteria available to the Health Steering Committee that will allow the Steering Committee to prioritize between the different types of services and special populations competing for capital investment. Comparison of competing proposals for widely differing types of services such as a Head Start facility and an substance abuse treatment facility will be difficult without carefully developed priorities and criteria for funding. Developing a ranking system for facilities that serve dramatically different constituencies will be difficult – and will necessarily require value judgments by the Commission about priorities for those types of services. Failure to develop simple and objective priority mechanisms or standards and criteria for review will subject the funding process to increasing political pressure and possible criticism of its funding decisions.

Finding: *Most expanded types of services will compete for the same match (except assisted living or other housing programs).*

Expanding the scope of Denali Commission funding to other health programs also would increase the competition for matching funds needed to complete construction of primary care facilities. The governmental grantors and the Rasmuson Foundation, which are the likely source of grant funds for the primary care facility program, will also make grants for other types of health and human service facilities. The availability of Denali Commission funds to construct other types of facilities will stimulate applications to HUD, Alaska Department of Community and Economic Development (A-DCED), USDA-Rural Development and the Rasmuson Foundation for matching funds. This could make the acquisition of matching funds more difficult for priority communities

wishing to construct a needed Primary Care Clinical facility and slow overall progress on completing the construction of all of these needed facilities.

Summary and Recommendations

The objective of expanding the scope of funding of Denali Commission health and human service infrastructure projects beyond the construction of village based primary care clinics is a challenge. There are many worthy projects that would, if funded, support the overall infrastructure needs for health and human services in rural regions. The data on the scope and cost of the unmet need for other types of service is incomplete. In addition the process of prioritizing and awarding these projects will be difficult since the Commission will have to prioritize between projects that serve widely different needs and populations.

To ensure the Denali Commission completes its initial objective of providing primary care services, the Commission should identify new partners with expertise in the new types of service delivery and support additional local, statewide and regional planning that focuses on the full range of health and human services facilities needs by community and region. This effort should help to develop regional priorities and to provide criteria for development and evaluation of proposals.

**PART I: PRIMARY CARE:
ESTIMATED NEED AND FUNDING STREAMS**

Background

Since FY2001 the Commission has been actively funding the design and construction of new primary care facilities. Utilizing the community priorities and ranking established by the *Alaska Rural Primary Care Facility Needs Assessment*, the Denali Commission has made a focused effort to encourage communities in the highest priority⁶ groupings to apply for clinic improvement and replacement. The Commission has supported high priority communities' applications by providing direct technical assistance as well as project design and management assistance through ANTHC.

The Commission has been successful in developing projects in the high priority communities. A little over one third of the communities ranked in Groups 1-5 have received project funding. About a fourth the communities with middle rankings of Groups 6-10 have received project funding and approximately 10% of communities with ranking over Group 10. In total, almost one quarter of the communities surveyed in the initial feasibility study have received funding for planning, design or construction.

**Primary Care
Number of Communities with Projects**

Community Priority Group	# of Communities	# Communities with projects	% Communities with projects
Priority Group 1-5	149	54	36%
Priority Group 6-10	51	12	24%
Priority Group 11-14	88	8	9%
TOTAL	288	87	26%

Source: Denali Commission Project Database

The Commission is hopeful that completion of all primary care facilities identified in the *Alaska Rural Primary Care Needs Assessment* will occur within five to seven years. The Commission requested that annual funding streams be identified to help realize this goal. In addition, staff has identified the issue of obtaining the required cost share, or match, as a possible barrier for many communities. There is intense competition for these matching funds.

⁶ Priority status was based on a scale developed in the *Alaska Rural Primary Care Facility Needs Assessment* that included the deficiencies in the current facility, health status in the community, isolation, dependency ratio, economic status, trauma rates and seasonal population.

Funding Progress in FY 2001 and 2002 on Estimated Unmet Need

The *Alaska Rural Primary Care Needs Assessment* estimated total funding needed for primary care space in rural Alaska in the table below.

Primary Care Clinics Unmet Need for Primary Care Funding

Unmet Need Category	Basis (GSF)	Amount (\$ millions)
New Space Individual Locations	305,000	\$99
New Multi-Community Clinics	130,000	\$52
Backlog of Repairs	330,000	\$102
TOTAL		\$253

Source: Alaska Rural Primary Care Facility Needs Assessment, table 1, p.4

This estimate represents the total cost of providing the estimated space and upgrades recommended in the Needs Assessment. This estimate includes both Denali Commission funds and required matching funds.

Projecting actual Commission funding levels over the next five to seven years will require that the estimates provided in the Primary Care Facility Needs Assessment be reviewed and adjusted to account for the following factors:

1. The estimates provided in the *Alaska Rural Primary Care Facility Needs Assessment* should be verified based on actual costs incurred in projects funded to date.
2. The total demand must be adjusted to account for communities which do not wish to construct new space, cannot afford to sustain the program, or do not have the capacity to provide the matching funds. These communities should be referred to another process to receive assistance to determine whether EMS services or strengthening health service networks with other communities will beset meet their needs for access to quality health care.
3. An estimate of the proportion of funding that will be required to fund necessary renovations, repairs, or other capital projects that the Committee or Commission determines are worthy of funding, but which are not included in the *Alaska Rural Primary Care Facility Needs Assessment*.
4. Estimates should be adjusted for inflation.

Validation of Unmet Need Cost Estimates

It is difficult to provide an accurate validation of the accuracy of estimates provided in the *Alaska Rural Primary Care Facility Needs Assessment*. Most projects currently funded are not yet complete so full actual costs cannot yet be determined. Appendix A identifies all projects with awards for construction in

FY2001 and FY2002 in communities that were assessed in the *Alaska Primary Care Facility Needs Assessment*. The unmet need for these projects was estimated to be approximately \$26 million. Total project costs for awarded to date for these projects are in excess of \$46 million, or about 79% over initial estimate for the total costs of the project. Although it is difficult to determine exactly the cause of this substantial increase, some trends do emerge from experiences to date.

Small Clinic Program - The small clinic program managed through the Alaska Native Health Consortium has carefully defined clinic prototypes and space standards. It has three “prototype clinics” ranging in size from 1500 to 2,500 square feet. Cost estimates were developed for each prototype and adjusted for location. Most of the smaller communities have relied on these prototypes and on ANTHC to provide construction management services for their projects. In some regions there has been variability in clinic size based on regional, rather than Denali Commission prototypes. Current estimated costs for the 35 small clinics that have been determined ready for construction in FY2003 total \$26.7 million (see Appendix B). Estimates from the *Alaska Rural Primary Care Facility Needs Assessment* for construction of these same facilities is \$24.5 million, or 10% less. In general, however, numbers of facilities and associated cost estimates for small clinics appear to be reasonably consistent. The recent expansion of the medium and large prototype clinics to include mental health and substance abuse will further increase the cost of this program.

In February 2003 the Health Steering Committee considered reports on Rural Dental Health and Rural Behavioral Health needs for facility space in the small clinic prototypes currently utilized by the Commission. Both reports recommended that the prototype clinic drawings be revised to include space for dental and behavioral health in the “medium and large” prototype in the small clinic grant program.

The Health Steering Committee recommended immediate action be taken to provide for additional space allocations for all communities which could demonstrate a need for and sustainability of this additional space. On February 28 the Commission issued an addendum to the Notice of Funding Availability for Primary Care Projects in FY03 to include this additional space as defined below.

Revised “Small” Clinic Space Guidelines
Effective February 19, 2003

Revised “Small” Clinic Space Guidelines (effective 2-19-03)	Year – round population			
	< 100	100 to 500	500 to 750	Greater than 750 or serving multiple communities
	“Small – Small”	“Small – Medium”	“Small – Large”	“Large” Clinic Program
Eligible clinic square footage (SF) for Commission construction funding	1500 SF	1990 SF	2460 SF	Applicant Defined
Additional SF based upon approved business plan for dental services “module”	0	360 SF	360 SF	Applicant Defined
Additional SF based upon approved business plan for behavioral health services “module”	0	220 SF	320 SF	Applicant Defined
Eligible SF with approved “modules”	1500	2570 SF	3140 SF	

These revised guidelines increased the space recommendation for “medium” sized clinics by 580 square feet or about 29% over the previously approved “prototype medium clinic” and the space recommended for “large” prototype clinics by 680 square feet or about 28%. The weighted average increase in space for all clinics in the small clinic program (including the “small” prototype which has no recommended increase in space) is 20%. This recommendation will have a financial impact on the total costs of completing the “small clinic” primary care projects.

It is projected that the total impact will be less than 20% because some clinics are already under construction or have substantially completed design. In other cases the village will not wish to add the modules due to program delivery issues or overall costs issues. In other cases individual villages will not be able to fund the increase in matching funding or demonstrate sustainability of the expanded facility. For the cost estimates provided below (near the end of Part I) it is estimated that only 60% of clinics participating in the “small clinic” program will include the mental health and dental space in the clinic prototype design.

Large Clinic Program - Overall actual costs from the large clinic program vary substantially from estimates provided in the *Alaska Rural Primary Care Facility Needs Assessment*. When the needs assessment document was developed the need for large or multi-community clinics was based on a preliminary analysis with limited information about expected demand for Large clinic funding. The total number of large and/or multi-community (sub-regional) clinics was estimated to be between 12 and 14 new facilities with an estimated average cost of \$4,000,000 each.

During the application process the Commission further defined “large clinics” to be those serving communities over 750 or more than one village (sub-regional centers). The estimate of demand for this type of facility has grown, from the original estimated 13 new facilities to 40 facilities⁷ currently. There are 17 facilities in the construction phase, 14 in the design phase, and 9 additional sites projected to have some type of need.

Much of the increased demand for large clinic construction can be explained by the rapid expansion of support for Alaska Frontier Health Initiative of the Community Health Centers Program, funded through Section 330 of the Public Health Service Act. Funding was first directed to support this initiative in the FY2001 HRSA appropriation. Funding was unanticipated at the time the needs assessment was completed. In the past three years this initiative has added over \$25 million in recurring grant funds annually to support primary care services statewide. This additional operational funding has allowed larger villages to support a higher level of provider and additional types (such as mental health providers, dentists, etc.) of health care providers of care in these communities and reduced the need to travel to regional centers for more complex urgent and primary care.

Primary Care Clinics
Number of Community Health Center Recipients and Sites

Year	# Grant Recipients	# Communities Facilities
1974- 1994	1	1
1995	2	2
1997	3	8
1999	5	13
2001	9	29
2002	19	49
2003 (estimated)	24	59

Source: Alaska Primary Care Association

Prior to expansion of Section 330 Program with the “Alaska Frontier” Program, there had been only five Community Health Center recipients in Alaska operating facilities in 13 locations. By the end of FY2003 this is expected to expand to 24 recipients providing services in 59 sites across the state. Expansion has enhanced the sustainability of primary care health services in many large sub-regional centers. Sustainability has also been enhanced in communities without a large Native population that had previously been unable to sustain a primary care program due to low levels of health insurance coverage, high costs, lack of economies of scale, and the lack of a primary public funding

⁷ Denali Commission, Project DataBase, Performance Indicators for Large Clinics, <http://steller.denali.gov>

source such as the Indian Health Service. It has also provided the capacity for many large village based clinics, located in primarily Native communities, to expand to sub-regional centers supporting a higher level of health care services across several communities.

It is likely the Alaska Frontier Program will continue to expand. Many of the newer programs have not yet added oral health or mental health components to their programs. These elements are a focus for the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care and additional funding is available nationwide to support these functions. As new projects mature and expand into oral and mental health services, it is expected that the demand for clinical space will increase.

The State Division of Public Health (Section of Community Health and EMS, Primary Care and Rural Health Unit) has a contract with the City of Unalaska to work with the Illiuliuk Clinic to develop models for an extended stay primary care clinic. The contract requires the city to develop models that include conditions of participation as well as two reimbursement methodologies (one for non-tribal clinics and one for tribally operated clinics). In addition, the Division is working with the Alaska Congressional Delegation, Federal Office of Rural Health Policy, and the Centers for Medicare and Medicaid Services to develop a demonstration project that would include reimbursement from Medicare and, potentially, Medicaid. These efforts may impact the facility space demands for “large clinics” especially for extremely isolated locations.

In addition to the increase in the number of multi-village “large” clinics likely to be constructed, the actual cost per facility has been difficult to estimate. Unlike the small clinic program, there is no prototypical “large clinics” for different sized communities. Clinics may be sized utilizing the population of a sub-regional area. New construction/major expansion projects for “large clinics” have ranged in costs from just over \$1 million to over \$8 million.

In viewing the increased demand for large clinics and reviewing actual construction costs for facilities this size, it is clear the original estimate of \$52 million in capital needs for new large clinics is an underestimate of projected costs for these clinics. The Health Steering Committee has noted this increase in costs for large clinics and has a pending issue of whether the “Large” clinic program should have a cost ceiling for maximum Commission funding

In order to provide a more accurate estimate of the unmet need for this type facility, the Commission should consider another effort to survey communities which may develop “large clinics” in the future or could collaborate with the State of Alaska to insure the necessary information to fully define this need will be available from the upcoming comprehensive state-wide health facility planning effort of the State of Alaska

Other Health Infrastructure Projects - The Denali Commission has funded several health projects that support the overall goals of the infrastructure development program. These projects were either statewide in nature or located in communities not reviewed in the *Alaska Rural Primary Care Facility Needs Assessment*. These included statewide EMS projects as well as projects in Anchorage, Fairbanks, Bethel and Barrow (see table below).

Other Health Infrastructure Projects

Award Partner(s)	Project Description	Community	Matching Funding	Denali Commission Funds	Total Project Funding
Anchorage Neighborhood Health Center	Fairview/Mountain View Assessment - Planning	Anchorage		\$ 190,000	\$ 190,000
SCF- Fireweed Clinic	Dental Equipment	Anchorage	\$16,825,481	\$ 884,480	\$ 17,709,961
Arctic Slope Native Association	Life-safety code repair & upgrade of Greist Center	Barrow		\$ 852,000	\$ 852,000
Alaska Native Tribal Health Consortium	Repair/Renovation	Bethel		\$ 172,292	\$ 172,292
Interior Neighborhood Health Corporation	Primary Care Facility	Fairbanks	\$ 3,343,000	\$ 3,343,000	\$ 6,686,000
Chugachmuit	Dental Training Center	Seward	\$ 26,250	\$ 304,750	\$ 331,000
State of Alaska, Department of Health and Social Services	Code Blue - EMS needs	Statewide	\$ 6,713,444	\$ 501,710	\$ 7,215,154
TOTAL			\$26,908,175	\$ 6,248,232	\$ 33,156,407

Discretionary projects not specifically included in the estimates in the *Alaska Primary Care Facility Needs Assessment* account for approximately 12% of revenue expended in Health Infrastructure development during FY2001 and FY2002. It is difficult to estimate what types of projects will continue to meet these criteria, but undoubtedly some fully discretionary projects will continue to be approved.

Demand for Primary Care Facilities by Rural Communities

Not all communities listed in the *Alaska Primary Care Facility Needs Assessment* as needing new clinic space will actually build or renovate their clinic. Some communities will not build “needed” new/renovated facilities because:

- They do not choose to build or renovate a clinic because they are satisfied with an existing clinic.
- They do not have and cannot get the matching funds.
- They cannot complete the application process.

The initial response rate to the *Alaska Rural Primary Care Needs Assessment* was over 75% or 218 communities of 288 surveyed. This gives an indication of the perceived demand from these communities. Meeting this benchmark is probably realistic if the Commission continues to fund projects for at least another five years.

Estimated Cost Share for Denali Commission Funding for Primary Care Facilities

One of the factors affecting the eventual demand for Denali Commission funding will be the ability of communities to access the necessary matching funds required to support the project.

The Commission's Health Facility program by statute requires a match of 20% (economically distressed community) to 50% (non-distressed) of construction costs. The Denali Commission has chosen to fund conceptual planning and design costs at 100% (with some exceptions) to allow communities to clearly define the match requirement and have time to apply. In the initial two years of the health facilities program many recipients in the planning phase did not have to demonstrate match. This allowed the Commission to commit a high level of funding in FY2001 and FY2002.

A little over two-thirds of projects funded in FY01/02 were in distressed communities that would qualify for a funding level of 80%. If all projects in distressed and non-distressed communities were similar in size, total funding level would be 69%, requiring a match of 31%. In reality the match level will be slightly higher since many of the more expensive "large clinics" are located in non-distressed communities. In FY01/02, the average match requirement was approximately 34% of total project cost. In FY03, staff at the Denali Commission estimated that projects with total costs of \$37.7 million will be ready for construction, requiring a match of \$13.7 million. This is a required match rate of approximately 36% of project cost⁸.

Match funds for Denali Commission projects can be divided into three broad categories of funding.

1. Public and Foundation Grant Funds that are received by the applicant based on a grant application.
2. Cash or in kind resources available to the applicant from the community or regional health corporation responsible for the village.
3. Loans made by a financial institution that usually utilize a deed of trust on the new facility for security.

Public and Foundation Grant Funds - Public grant funding for primary care clinic construction currently comes from a variety of State and Federal

⁸ Briefing paper Denali Commission – Estimated Cost Share Match for FY03 Clinic Projects, November 7, 2002

programs. Most have categorical restrictions and in general are directed at low-income communities and/or Alaska Native communities. Private grant funds have come primarily from the Rasmuson Foundation.

Contribution to rural health facility capital improvements over the last three years have averaged about \$6.2 million from the major public and private contributors listed below.

USDA Rural Development - The USDA Rural Development Program provides support for a wide range of community facilities including health care facilities. It is strictly limited to communities with a population less than 20,000. It can provide grant funds to public or nonprofit entities in distressed communities and guaranteed loans to other communities. In the three-year period beginning in FY2000, the USDA reports that it funded six health projects in rural areas with a total of \$6.7 million in grants and \$5.5 million in loans. The program coordinates closely with the Denali Commission to provide matching funds to the maximum number of community clinic projects.

**Primary Care Clinics
Anticipated Public and Foundation Grant Funds**

Program	Average Annual Contribution FY00-FY02	Comments
USDA Rural Development Grant Funds	\$2,250,000	Funds all community projects. Grant funds are only available to low income communities.
HUD – Indian Community Development Block Grant	\$2,160,000	Only available to Alaskan Native Villages.
Alaska Community and Economic Development CBDG Grant	\$375,000	Only available to low income communities incorporated under Alaska statutes.
IHS Equipment Fund (inc. both dental and health equip. funds.)	\$700,000	Only available to tribes or tribal organizations.
VSW sanitation	\$500,000	Estimate
Rasmuson Foundation* (FY2002 contributions only)	\$2,067,000	Broad discretion on funding awards. Total annual funding will average \$20,000,000 per year into the future.
TOTAL	\$7,852,000	

**Based on last three years contribution except Rasmuson is one-year only
source: Private communication with IHS, ADEC, ICDBG, USDA, and Rasmuson Foundation*

HUD - Indian Community Development Block Grants (ICDBG) - This program is highly competitive and only available to Alaskan Native villages. It is funded at an annual level of about \$6 million and funds a wide variety of community facilities. Denali Commission staff estimates that about \$1.5 million annually will be available from this source. ICDBG staff report over the past three years

about \$6.5 million of funding has been approved in support of rural health clinic projects. The Denali Commission has recently provided \$500,000 in funds in a collaborative effort that fund ICDBG projects to the maximum extent relieving HUD of the requirement and allowing additional facilities to be funded with matching funds.

Alaska Department of Community and Economic Development - HUD Community Development Block Grant Pass Through Funds. The State of Alaska receives approximately \$3.3 million per year from HUD grants for public facilities. Applicants must be an incorporated municipality with a majority population having low or moderate income. In the last three years the A-DCED awarded a total of \$10.2 million. Support was provided for four community clinics and one mental health facility totaling \$1.125 million. The annual average contribution from this fund toward health clinic construction has been approximately \$375,000 per year.

IHS Tribal Clinic Equipment Funding - For the past five years IHS has provided funding for equipment in tribally constructed facilities. The agency has two funding processes, one limited to dental equipment for new facilities and one to support general equipment. Over the past three years the agency has provided \$2.1 million for equipment in new tribal owned health clinics, or about \$0.7 million per year.

VSW Sanitation Program provides funds to hook up village clinics to water and sewer. The Denali Commission has estimated that an estimated \$500,000 per year will be available from this fund.

Rasmuson Foundation – The Rasmuson Foundation is an Alaska-focused private foundation that supports nonprofit organizations across the state. The foundation was endowed with a large gift in December of 2000 from Elmer Rasmuson. It expects to make grants for approximately \$20 million per year to support nonprofit organizations across the state in perpetuity. The first year of funding at these levels was in FY2002. The Commission expects that the foundation will provide substantial support to communities seeking Denali Commission funding, especially smaller communities needing 20% match with no apparent source of funding. Denali Commission has opened discussion for a block grant from the Foundation to provide efficient leveraging to Foundation funds in an effort to support multiple construction projects.

Cash and In Kind contributions from applicants - Applicant sources of matching capital include; donated land and materials (such as locally available fill), cash match from the community, cash match from a regional tribal organization, or cash from the reserves of community nonprofit entities which have been organized to provide health services in the community

Communities, tribal, or nonprofit organizations will generally only utilize private capital for match after all other sources of grant revenue are exhausted. There are distinct differences in the types of projects funded by the Commission and the ability of the entity receiving the project to raise a matching share.

Most clinics in smaller communities are owned by the community and operated by a larger regional entity such as a Tribal Health Corporation. These communities typically have no tax base and very limited revenue streams to support the facility. Over 90% of smaller communities rely on a regional corporation to hire providers and operate the health services provided from the facility.

Many of these small villages, however, do receive a discretionary grant from their Regional Health Corporation. These grants provide support for village identified health priorities. In cases such as Maniilaq, regional corporations have also provide direct cash support for village clinic construction. Many regional corporations have been reluctant to assume the responsibility for funding small village clinics because historically, this has not been a regional corporation responsibility. Current demand could quickly overwhelm the cash reserves of many regional corporations.

Loans – In general loans have been utilized to support projects that have been funded under the “large clinic” programs. Regional nonprofit organizations are more willing to utilize their debt capacity to obtain loans to support sub-regional multi-village clinics because this responsibility has traditionally been assumed by these entities. These facilities serve larger populations and can often generate substantial increases in operating revenue as the clinic facility expands. Clinics with support from either the IHS or the Section 330 Community Health Centers program are allowed to charge back depreciation and interest costs of loans for capital expansion. These clinics are usually operated by regional tribal organizations or larger community nonprofits that can qualify for and obtain loans based on the cash flow of the operations housed in the facility.

Summary

Existing sources of matching grants appear to be adequate to sustain levels of contribution of approximately \$8 million per year based on funding levels of the past three years. This level of support is dependent on: no new types of funding being made available, relatively constant appropriation levels from public sources, and continuing support from Rasmuson Foundation.

Estimates for the level of support from other sources of private capital (cash or loans directly from the village or regional corporation) are more difficult to determine. Amounts of private capital will likely increase as more large clinics are approved and as smaller communities and regional corporations have time to

plan for and incorporate the need for this capital into their long term fiscal plans. The best estimates of the total private capital that would be available annually would be about \$5 million, making the total match available annually about \$13 million.

Revised Estimate of Unmet Need for Primary Care and Funding

The table below provides a revised estimate of the total unmet need for rural health facility infrastructure development. It also provides an estimate of demand for these projects, and funding levels that will be necessary from the Denali Commission over the next seven years.

The following adjustments are provided from the estimates in the *Alaska Rural Primary Care Needs Assessment* based on the data discussed above.

- New and renovated space adjusted by +10% for “small” clinics.
- Addition of space for dental and mental health services in medium and large clinic prototypes for the “small clinic” program. The projected increase relies on an estimate that 60% of the eligible clinics will be able to add the space that provides for a 20% average increase in clinic size (across all three prototypes). This would provide for an overall increase in costs for the “small” clinic program of approximately 12%.
- New multi-village clinics - For the revised estimate it is assumed that the number of new and expanded “large” facilities will increase to 40 facilities. The average cost of each large clinic will remain at \$4 million. This estimate will increase the unmet need from \$52 million to \$160 million, an increase of over 200% over initial estimates. This estimate would be reduced if the Commission adopted a ceiling on multi-village clinic construction costs contributions.
- Inflation – The estimate is inflated for four years to the mid point of construction with an inflation factor of 3% per year.
- Other projects - It is likely that the Commission will continue to fund other high priority health care projects that support the goal of health infrastructure development but are not within the parameters of the original needs assessment. An estimate of +5 % per year is provided for this purpose.

Primary Care Clinics
Revised Unmet Need for Primary Care Funding
(Absolute Total)

Unmet Need Category	Initial Estimate (millions)	Revised Estimate (millions)
New and Renovated Space	\$201	\$221
Add Dental and Mental Health Space @ 12%	0	\$27
New Multi-Community Clinics	\$52	\$160
Inflation of costs estimates to a 2004 midpoint		\$51
Other Health Facility Projects (not Primary Stand Alone Primary Care)	0	\$22
TOTAL	\$253	\$481

Source: Alaska Rural Primary Care Facility Needs Assessment, table 1, p.4

The table above projects an increase in cost of about 90% over original estimates. This is consistent with actual increases in projects reflected in Appendix A after adjustments are made for the additional dental and mental health space which was not included in the earlier projects. The table below projects Denali Commission funding and matching funds necessary to fully meet the unmet need estimated above.

The total projected need is reduced by a factor of 20% to allow for communities that will not apply for a new or renovated facility, or cannot demonstrate the ability to carry out the project. The need is further reduced by the amount already funded in FY2001 and FY2002 and by the expected FY2003 amount.

Estimate of Denali Commission Funding and Match Funds
(Sustainable Total)

	Total (millions)	Denali Funds (millions) 65%	Match Required 35%
Total Unmet Need	\$481	\$313	\$168
Demand Adjustment - 20% reduction	(\$96)	(\$63)	(\$34)
Funded in FY2001 and FY2002	(\$77)	(\$50)	(\$27)
Estimated Funding For FY2003	(\$54)	(\$35)	(\$19)
Total Remaining Unmet Need	\$254	\$165	\$89

Total costs to fund the expected demand for primary care infrastructure development after the FY2003 funding cycle is estimated at \$230 million. At current match requirements, the match will be \$81 million dollars and the Denali Commission requirement will be \$150 million.

Primary Care Clinic Construction
5 and 7-Year Cash Flow Estimates

	Total (millions)	Denali Funds (millions) 65%	Match Required 35%
Total Remaining Unmet Need	\$254	\$165	\$89
Annual Cash flow on 5 year schedule	\$51	\$33	\$18
Annual Cash flow on 7 year schedule	\$36	\$24	\$13

The table above provides annual estimates for cash flow required to fund the remaining unmet need in 5 years and in 7 years (after 2003) at current match levels. Based on estimates of the matching funds likely to be available it would appear that a more aggressive five-year funding cycle would require the development of additional sources of public grant funds for match, or efforts to increase the private funding available from Regional Corporations or larger entities operating the Section 330 Community Health Centers across the state.

PART II: OTHER HEALTH FACILITIES

HOSPITALS

Background

Alaska has 22 non-military general hospitals providing a broad range of primary, secondary and tertiary care services in 18 communities across the state. These hospitals are organized into two separate but increasingly integrated systems, the IHS/Tribal Health System which operates 6 small rural hospitals and one referral hospital in Anchorage and the private system of 8 very small rural hospitals of less than 25 beds, 4 medium sized facilities located in smaller urban areas including Juneau, Palmer, Ketchikan and Soldotna; and three large facilities over 100 beds in Fairbanks and Anchorage.

Alaska Hospitals Location and Number of Beds

Name	Location	Ownership Type	Licensed Beds
Providence Seward Medical Center**	Seward	Nonprofit	6
Wrangell Medical Center	Wrangell	Nonprofit	8
Petersburg Medical Center	Petersburg	Nonprofit	12
Sitka Community Hospital	Sitka	Nonprofit	12
Cordova Community Medical Center**	Cordova	Nonprofit	13
Samuel Simmonds Memorial Hospital	Barrow	IHS/Tribal	14
Bristol Bay/Kanakanak Hospital	Dillingham	IHS/Tribal	15
Valdez Community Hospital	Valdez	Nonprofit	15
Manilaq Medical Center	Kotzebue	IHS/Tribal	17
Norton Sound Regional Hospital**	Nome	IHS/Tribal	19
South Peninsula Hospital	Homer	Nonprofit	22
Providence Kodiak Island Medical Center	Kodiak	Nonprofit	25
Valley Hospital***	Palmer	Nonprofit	36
Ketchikan General Hospital	Ketchikan	Nonprofit	39
Yukon-Kuskokwim Delta Regional Hosp.	Bethel	IHS/Tribal	50
Bartlett Regional Hospital	Juneau	Nonprofit	55
SEARHC Mt. Edgecumbe Hospital	Sitka	IHS/Tribal	60
Central Peninsula General Hospital	Soldotna	Nonprofit	62
Alaska Native Medical Center	Anchorage	IHS/Tribal	156
Fairbanks Memorial Hospital	Fairbanks	Nonprofit	162
Alaska Regional Hospital*	Anchorage	For Profit	238
Providence Alaska Medical Center	Anchorage	Nonprofit	307

* For Profit Hospital

**Designated Rural Primary Care Hospital

*** Currently in process of sale/merger to for profit hospital which plans to replace the existing hospital with 72 bed facility

All urban hospitals in Alaska serve both urban and rural populations as the larger hospitals serve as a referral centers for higher levels of care that is beyond the capacity of the smaller rural hospitals. The smaller rural facilities serve primarily rural communities in surrounding areas and transient populations. They offer primary care and often, especially in the IHS/tribal system, support primary care services in small isolated clinics across a regional services area. The larger hospitals are often affiliated with facilities that provide primary care services to special populations. In Anchorage this includes the Alaska Native Primary Care Center at ANMC, the Family Medicine Program at Providence and the Veterans Facility at Alaska Regional.

In many respects, the low-volume, small rural hospitals operate like large clinics. They provide mostly primary care and emergency room services. Their increasing choice to be designated as “Critical Access Hospitals” further supports their similarity to large clinics. The Providence Seward Medical Center is a Critical Access Hospital, and the Cordova Community Medical Center and the Norton Sound Regional Hospital are in the process of converting to a Critical Access Hospital designation by year’s end. The major difference between the large clinics and the hospitals is in the ability of the hospitals to provide emergency room and inpatient services and to be reimbursed by all payers for these services. In addition, these hospitals are the essential factor in the presence of doctors in these communities.

All hospitals have continuing capital needs to modernize and replace their facilities and to acquire, upgrade or replace the expensive medical equipment necessary to meet the modern standards of medical care delivery. Failure to invest the funds to meet this need will eventually have disastrous financial consequences for hospitals.

Nationally concerns regarding the ability of small rural hospitals to acquire the needed capital to invest in capital improvements have led to several federal initiatives that focus on smaller rural hospitals, including federal loan programs for facilities with fewer than 50 beds, and higher payment rates for Medicare reimbursement for specially designated “Sole Community Hospitals or “Critical Access Hospitals”.

A national survey of almost 1,000 small rural hospitals⁹ completed in 2002 revealed:

- 38% of small rural hospitals have facility deficiencies that by law require renovation or remodeling to correct.
- Most hospitals need to borrow funds to correct these deficiencies.
- Most hospitals have the ability to borrow funds for capital projects.
- Older, low volume hospitals with operating losses often cannot borrow funds to meet their capital needs.

⁹ Stensland, J. et. Al., Capital Need of Small Rural Hospitals, Project Hope, May, 2002

Although Alaska has many differences in the structure of our health care system these findings apply to many of our small rural hospitals, especially those that are not included in the IHS/Tribal health care system.

Need for Capital Investment in Alaska Hospitals

The need for capital investment in the current hospitals in Alaska includes the need for replacement of current facilities, large capital projects (over \$1 million) for expansion, renovation, and major equipment, and continuing replacement and upgrading of smaller pieces of medical equipment and smaller renovation projects that occur on a continuing basis.

Facility Replacement or Major Expansion- There are currently 5 planned hospital projects for replacement or major expansions that appear likely to be initiated in the next 5 years. The Samuel Simmonds Memorial Hospital in Barrow and the Norton Sound Regional Hospital in Nome are both currently scheduled for replacement by the IHS. These facilities have both completed all conceptual planning and are currently ranked number 2 and 3 on the nationwide priority list and could receive design funds in the next two to five years depending on Congressional appropriation levels. Historically the IHS has provided full funding for replacement facilities when they are constructed.

Valley Hospital in Palmer is working with Triad Hospitals, Inc., a for-profit investor owned hospital corporation, which has offered to take over ownership and either expand the current facility significantly or build a new replacement facility in Palmer. Bartlett Memorial Hospital in Juneau is planning a new bed tower and major renovation of the current facility. This project is funded by a new city sales tax and debt financing and is ready to go out for bid. Valdez Community Hospital is also actively engaged in planning for replacement facility but has not identified all the funding necessary to complete a new facility at this time.

Alaska Hospitals Replacement or Major Expansion Hospital Projects

Name	Project	Estimated Costs	Source of Funding
Bartlett Memorial (Juneau)	New Bed Tower and Renovation	\$42,000,000	Local Tax/Bonds
Norton Sound Regional Hospital (Nome)	Replacement	\$100,000,000	IHS
Samuel Simmonds Memorial (Barrow)	Replacement	\$110,000,000	IHS
Valdez Community Hospital	Replacement	\$24,000,000	Debt/unknown
Valley Hospital (Palmer)	Replacement or major expansion	\$50,000,000	Investors
TOTAL		\$322,000,000	

Source: Private correspondence with Alaska State Hospital and Nursing Home Association, individual hospitals and the Alaska Area Native Health Service

Planned Major Capital Projects. Modern hospitals develop strategic master facility and asset management plans that identify the resources necessary to support the strategic objectives of the health care facility. These plans evaluate the need for new or renovated space and equipment and define the investment essential to maintain the quality of care and the financial well being of the hospital.

The table below provides estimates of some of the major projects (over \$1,000,000) currently in planning for the Alaskan hospitals. The total statewide level of funding

**Alaska Hospitals
Large Capital Projects**

Facility	Project	Estimated Costs	Source of Data
Wrangell Medical Center	Remodel	\$4,000,000	ASHNHA
Alaska Regional Hospital	New Gamma Knife	\$5,400,000	CON
Norton Sound Regional Hospital	Lobby/Lab upgrade	\$1,400,000	IHS
Alaska Native Medical Center	Phase I - Renovations/expansion	\$15,000,000	Hospital
Bristol Bay/Kanakanak Hospital	Mental Health Bldg	\$2,600,000	Hospital
	Dental Building	\$3,900,000	Hospital
	Outpatient Expansion	\$5,000,000	Hospital
Samuel Simmonds Memorial Hospital	Outpatient Remodel	\$1,000,000	IHS
Search Mt. Edgecumbe Hospital	Lab/Pharmacy expansion	\$1,400,000	Hospital
	Dental Expansion	\$1,200,000	Hospital
	MRI	\$1,000,000	Hospital
Yukon-Kuskokwim Delta Regional Hospital	Bethel Primary Care Center	\$10,000,000	Hospital
	Staff Housing (ongoing HRSA funding)	\$10,000,000	Hospital
Cordova Community Medical Center	Renovations	\$500,000	ASHNHA
Fairbanks Memorial Hospital	Additional space	\$5,500,000	CON
Petersburg Medical Center	Renovation and CAT scanner	\$2,000,000+	ASNHA
Providence Alaska Medical Center	+20 critical care units	\$7,000,000	CON
	Imaging equipment/PET scanner	\$5,600,000	CON
South Peninsula Hospital	New ER/ambulatory Expand office bldg	\$7,500,000	ASHNHA
Valley Hospital	Misc. Surgery equipment	\$2,000,000	CON
TOTAL		\$90,000,000	

Source: Private correspondence with Alaska State Hospital and Nursing Home Association, individual hospital, State of Alaska Certificate of Need Applications

for this level of capital investment is difficult to determine but under current funding scenarios can be estimated to be between \$10 and \$20 million annually. The projects listed above were all described as “high priority” projects that the hospital finance within existing revenue streams and are projected to be constructed within the next five years. Many of the projects have funding committed and are already in the design or construction phase.

Currently most of these projects are planned to be funded either from a combination of hospital cash reserves and debt or in the case of the IHS/Tribal facilities partially from cash reserves, debt and maintenance and improvement funds received from Congress that are pooled and prioritized on a state wide basis.

Most of the hospitals in Alaska have facility master plans that identify a large number of additional projects that would be desirable to meet the long-term goals and needs which have been identified in the hospital. These additional projects run in to the tens of millions of dollars in the larger facilities.

Unlike the small village clinic construction projects, the availability of matching funds is unlikely to be an issue with most of these projects. The addition of Denali Commission or other resources to support capital projects on the list above would have the likely result of accelerating the construction of these projects and moving projects not in “high priority” status on to the list from the hospital master plan as the additional resources for investment into the capital needs become available.

Other capital investment - In addition to the major capital projects most Alaska hospitals also have ongoing capital funding needs for replacement and upgrade of equipment and minor building component replacement and renovation. In general these costs are included in the annual budget cycle and are funded from operational revenue. In the IHS/Tribal system facilities revenue may also be available from the M&I pool stated above. The ANTHC M&I pool averages about \$6 million per year and funds both major (over \$1,000,000) and smaller needed capital projects. Over the past 3 years about half of the funding from this pool has been approved to support smaller capital projects. The total statewide funding for this level of capital investment is difficult to estimate but the Alaska State Hospital and Nursing Home Association (ASHNHA) estimates the annual commitment to be between \$10 and \$20 million per year.

Needed Hospital Improvements for Primary Care Services - Differentiating “Primary Care” from secondary and tertiary care services in Alaskan hospitals is very difficult. The definition of primary care is evolving from one that was initially based on where the care was provided: to what type of provider gave the care, to a description of the characteristics of primary care. Barbara Starfield, in her 1992 book “Primary Care: Concept, Evaluation and Policy”, wrote that primary care must have four key components: first contact, continuity of care, comprehensiveness, and coordination.

All Alaskan hospitals provide some primary care services. Most of the small rural hospitals in isolated rural Alaskan communities are the sole providers of all medical care in the community for a large proportion if not all of the community meet the characteristics of a primary care provider. In the medium size facilities and larger facilities a substantial portion of the services may be primary care services but this varies widely between the facilities depending on the organization of the health care system and the scope of services offered by the facility and the other types of providers which may be available in the community.

Alaska Hospitals
Estimate of “Rural Primary Care Capital Projects”

Facility	Project	Estimated Costs	Source of Data
Wrangell Medical Center	Remodel	\$4,000,000	ASHNHA
Norton Sound Regional Hospital	Lobby/Lab upgrade	\$1,400,000	IHS
Bristol Bay/Kanakanak Hospital	Mental Health Bldg	\$2,600,000	Hospital
	Dental Building	\$3,900,000	Hospital
	Outpatient Expansion	\$5,000,000	Hospital
Samuel Simmonds Memorial Hospital	Outpatient Remodel	\$1,000,000	IHS
SEARHC Mt. Edgecumbe Hospital	Lab/Pharmacy expansion	\$1,400,000	
	Dental Expansion	\$1,200,000	
Yukon-Kuskokwim Delta Regional Hospital	Bethel Primary Care Center	\$10,000,000	Hospital
Cordova Community Medical Center	Renovations	\$500,000	ASHNHA
Petersburg Medical Center	Renovation	\$1,000,000	ASHNHA
South Peninsula Hospital	New ER/ambulatory expansion/expand office building	\$7,500,000	ASHNHA
TOTAL		\$39,500,000	

Source: Private correspondence with Alaska State Hospital and Nursing Home Association, individual hospitals

The above table makes some effort to segregate the projects that appear to obviously support primary care services. This process probably understates the total need for primary care projects as many hospital capital projects facility infrastructure supporting primary care as well as higher levels of care.

Using these estimates and the total current cost for the “unmet need” for capital investment in primary care services in hospitals is summarized below. These costs have all been subjected to some type of local priority system and are likely to be constructed (or be underway) under the existing funding scenarios without Denali Commission funding over the next 3 to 5 years.

Total Estimated Unmet Need for Primary Care

Type of cost	Total Project Costs
Major Expansion and Replacement (Valdez, Nome and Barrow)	\$222,000,000
Large Capital Projects	\$40,500,000
Small Capital Investment (annual)	\$6,000,000
TOTAL	\$268,500,000

For the majority of Alaskan hospitals the participation of the Denali Commission in the funding of these projects will enhance and accelerate the ability of the hospital to invest in needed capital projects and may enable these facilities to add additional projects to the list but it will not affect the long-term financial success of the hospital.

For some Alaskan hospitals, however, especially the small, low volume, non IHS/tribal hospitals which are currently sustaining an operating loss, capital from the Denali Commission may enable these facilities to provide needed investment in critical capital projects that would otherwise be impossible. What impact this investment would have on the long-term sustainability of these facilities is impossible to predict.

Many of these small hospitals have sought or are considering seeking designation as Critical Access Hospitals (CAH). The CAH program is a federal safety net device, to assure Medicare beneficiaries access to health care services in rural areas. It was designed to allow more flexible staffing options relative to community need, simplify billing methods and create incentives to develop local integrated health delivery systems, including acute, primary, emergency and long-term care. There are 12 hospitals eligible for CAH designation in Alaska. Five hospitals (Seward, Valdez, Petersburg, Wrangell, and Sitka) have already converted and three more (Kodiak, Nome and Cordova) will in the next few months. The tribally operated Indian Health Service hospitals in Kotzebue, Dillingham and Barrow will also consider the option in the near future. Only the South Peninsula Hospital in Homer is not expected to convert in the foreseeable future.

NURSING HOMES

Background

Nursing homes provide skilled nursing care and rehabilitation services to people with illnesses, injuries or functional disabilities. Most of the residents of nursing homes are elderly. The level of care provided by nursing homes has increased significantly over the past decade. Many homes now provide much of the nursing care that was previously provided in a hospital setting. As a result, most nursing homes now focus their attention on rehabilitation, so that their clients can return to their own homes as soon as possible. There are 15 licensed nursing homes in Alaska.

**Nursing Homes
Location and Number of Beds**

Nursing Home	Location	Licensed Beds	% Occupancy August 2002
Alaska Regional Hospital TCU*	Anchorage	16	44%
Mary Conrad Center	Anchorage	90	98%
Providence Extended Care Center	Anchorage	224	95%
Cordova Community Medical LTC**	Cordova	10	90%
Denali Center	Fairbanks	90	90%
South Peninsula Hospital LTC	Homer	25	100%
Wildflower Court	Juneau	44	98%
Ketchikan General Hospital LTC	Ketchikan	46	28%
Providence Kodiak Medical LTC	Kodiak	19	95%
Quyanna Care Center	Nome	15	100%
Petersburg Medical Center LTC	Petersburg	15	113%
Sitka Community Hospital LTC	Sitka	10	80%
Wesley Rehabilitation And Care Center	Seward	66	45%
Heritage Place	Soldotna	60	90%
Wrangell Medical Center LTC	Wrangell	14	100%

* TCU - Transitional Care Unit

** LTC - Long-term Care Unit

In addition to licensed long term care (nursing home) facilities, hospitals in Alaska are allowed to certify beds that can be used for acute or long-term care, depending on need. The Swing Bed Program is a federally approved program for small rural hospitals. It is designed to be short term. A predetermined number of hospital acute care beds can be designated as swing beds with the understanding that these beds revert to acute care beds if the need arises.

**Long-term Care Swing Beds
Location and Number of Beds**

Nursing Home	Location	Licensed Beds	% Occupancy August 2002
Bristol Bay / Kakanak Hospital	Dillingham	4	0%
Central Peninsula Hospital	Soldotna	8	50%
Cordova Hospital	Cordova	4	0%
Providence Kodiak Island Medical Center	Kodiak	6	33%
Petersburg Medical Center	Petersburg	5	0%
Providence Seward Medical Center	Seward	4	0%
Sitka Community Hospital	Sitka	4	0%
South Peninsula Hospital	Homer	4	100%
Valdez Community Hospital	Valdez	15	33%
Valley Hospital	Palmer	4	0%
Wrangell General Hospital	Wrangell	4	0%
Yukon-Kuskokwim Regional Hospital	Bethel	3	0%

Need

There is no statewide assessment of need for nursing home upgrades or construction. Most of the known capital facility needs are reflected in Certificate of Need (CON) letters and applications. The table below provides a summary of letters of intent and applications submitted to the Alaska Department of Health and Social Services CON office for the years 2000 through 2002. In addition, information from the Alaska State

**Nursing Homes
Certificate of Need (CON) Requests and Action**

Nursing Home	Request	Action
Mary Conrad Center Anchorage	Convert one assisted living bed to a nursing home bed	Letter of Intent (2/00)
Maniilaq Association Kotzebue	Build a 15-bed nursing home co-located with the Maniilaq Health Center.	Letter of Intent (3/01)
Sitka Community Hospital Sitka	Convert unused space to 5 nursing home beds	Approved (2/02)
Valdez Community Hospital Valdez	Build a new hospital that would include 10 nursing home beds	Approved (2/02)
South Peninsula Hospital Homer	Add 5 new nursing home beds	Letter of Intent (10/02)
Wildflower Court Juneau	Convert 11 assisted living beds to nursing home beds	Allowed to convert adult day care space to a maximum of 5 new nursing home beds (12/02)

Hospital and Nursing Home Association indicates that new nursing home facilities are needed in Bethel, Nome and Dillingham.

Estimated Costs

The CON process requires that hospitals or organizations submitting applications provide the estimated cost of the project. Any capital project (facilities or equipment) in excess of \$1 million dollars must receive approval through the CON process. In addition, any addition or re-configuration of acute or long-term care beds must receive approval because the changes may impact Medicaid expenditures. The cost of new nursing home facilities in Bethel, Nome and Dillingham is unknown.

Nursing Home CONs Costs of Facility Upgrades and Construction

Nursing Home	Request	Cost
Mary Conrad Center	Convert one assisted living bed to a nursing home bed	No cost.
Maniilaq Association	Build a 15-bed nursing home co-located with the Maniilaq Health Center.	Skilled nursing wing (\$6 million) Additional therapy and administration space (\$4 million)
Sitka Community Hospital	Convert unused space to 5 nursing home beds	\$30,000
Valdez Community Hospital	Build a new hospital that would include 10 nursing home beds	Cost of new 21-bed replacement hospital is \$24.1 million.
South Peninsula Hospital	Add 5 new nursing home beds	\$25,000
Wildflower Court	Convert 11 assisted living beds to nursing home beds	Unknown

Source of Funding

Most of the capital costs for new facilities in the table above will be covered by existing revenue sources, including local bonding, tax revenues and federal appropriations through the IHS.

Program Partners

The majority of nursing homes in Alaska are either co-located or adjacent to hospitals. This allows efficiencies in construction, management and patient services.

Sustainability

Long-term sustainability will be dependent on demand for services and generation of patient revenues. With the current trend towards in-home care and augmented assisted living, it is not clear whether the planned beds are sustainable in Kotzebue or Valdez.

ASSISTED LIVING

Background

Assisted living homes licensed by the Division of Senior Services are part of a continuum of home and community based services for frail elderly and people with physical disabilities. Assisted living homes can often provide cost effective care to support frail elders and other people with disabilities in their communities, when they can no longer remain in their own homes.

The first of these homes was licensed by the state in 1995. As of February 2003, there were 143 homes serving seniors and adults with physical disabilities. Most of the homes are privately operated for-profit small businesses, serving fewer than six people. Large homes include the six Alaska Pioneer and Veteran's Homes, and two private homes in Anchorage.

Most Alaskan assisted living homes are located in urban centers. Rural assisted living homes are located in Barrow, Kotzebue, Tanana, Dillingham, Wrangell, Seward, and Kodiak. Three of these homes receive continuing supplemental funding, two from state grant funds (Kotzebue and Tanana), and one (the Barrow home) from North Slope Borough general tax revenues. A new home is currently under construction in Petersburg.

The State of Alaska Division of Senior Services, recognizing the need for more rural assisted living homes, successfully applied to the Robert Wood Johnson Foundation for a three-year grant under the Coming Home Program. Through this program, Alaska, along with seven other states, has received technical assistance and enough funds to provide rural outreach and community education, and to begin the strategic planning process on local, regional, and statewide levels. The NCB Development Corporation, a nationally recognized and experienced developer of affordable assisted living nationwide, has provided the technical assistance to all of the RWJF Coming Home Program grantees. The Alaska Coming Home Program Advisory Committee has active participation from HUD, AHFC, USDA RD, AMHTA, ANTHC, Denali Commission, Association of Alaska Housing Authorities, various state agencies, and representatives from rural service providers.

Need

In January of 2003, the Alaska Coming Home Program developed a list of rural communities recommended for assisted living home development. The rural focus of recommendations is consistent with the Denali Commission mission and is based on the EMS Community Levels of Care, which are utilized through out this report.

**Alaska Coming Home Program
Prioritization of Technical Assistance for Assisted Living Development**

Priority	Criteria	Communities	
First Priority	Level III community with no current senior assisted living home (ALH) or other residential Long Term Care (LTC)	Bethel	
Second Priority	Level III community with no senior ALH and some residential LTC	Cordova Valdez Petersburg (in development)	Nome
	Level III community with small private senior ALH and some residential LTC	Seward Wrangell	
Third Priority	Level II isolated Communities with pop >1000 with no senior ALH	Craig Haines	Metlakatla Unalaska
	Level II Highway communities with pop>1000 with no senior ALH	Anchor Point Delta Junction Tok Ridgeway	Big Lake Nikiski Healy
	Level II communities with no senior ALH, pop <1000 but serve area with pop>1000	Glennallen Galena Aniak Naknek Sand Point	Emmonak Ft. Yukon Gamble Togiak Unalakleet

All of the above communities have some capacity for success. Level 1 villages and small Level II subregional centers are encouraged to develop other home and community based services, including independent senior housing, meal services, transportation services, home health, and chore services.

The above priorities take into account some important factors (population of community or service area, and the availability/sophistication of health facilities, transportation resources, and residential long-term care resources). It does not consider the level of community interest or support, availability of other home and community based services, actual demand, site availability, infrastructure, workforce availability, sustainability, or other important considerations. A more detailed business plan would have to consider all of the variables.

Estimated Costs

The Division of Senior Service has not provided estimates for the total costs of developing assisted living homes on the recommended priority list. The Division did, however, cite the Dillingham Assisted Living Home (Marrulut Eniit) as a model for development for rural communities of similar size. This home, licensed for 15 people, serves a regional population in Bristol Bay of about 7,700 and was opened in

early 2000. Its capital costs were funded with capital contributions from the Alaska Housing Finance Corporation, Federal Home Loan Bank, HUD ICDBG grants, and smaller contributions from local tribal councils. The facility was completed at a cost of \$2,323,645 for planning, design, construction and furnishing. The cost of construction for assisted living is similar to the cost of construction of other community facilities and will vary according to the community.

The cost of applying to multiple funding sources is considerable, in terms of money, time, and use of resources. The assisted living home in Dillingham was developed by a sophisticated and experienced developer (Cordes Developer, Inc.). Even so it took three years to stitch together seven different capital funding sources, plus various donations, such as land from the City Council. It may not be reasonable to expect communities to either hire outside for-profit developers (who must be attracted to the project), or to have the expertise and money to successfully compete for multiple complexes funding sources.

Source of Funding

Several financing programs are currently available to support the development of assisted living homes. This support includes:

- Grants for predevelopment and planning costs.
- Grants for the capital costs of construction and furnishing serving low-income individuals.
- A variety of loans and loan guarantees.

The list below is a partial list of the most active funding agencies that have been used in Alaska to support the planning, design, and construction of assisted living facilities.

Private Capital – The largest number of assisted living facilities are privately owned homes serving a small number of residents. Privately owned homes are located primarily in non-isolated communities. There has been little interest in building or operating assisted living programs from individuals in isolated rural areas. In 2003, the Coming Home Program plans to begin a marketing campaign encouraging individuals to open small privately owned homes by promoting the Alaska Housing Finance Corporation's Assistance Provider Interest Rate Reduction Program to people in rural communities.

Grant and Loans - There are many sources of private foundation and public funds available for the construction of assisted living facilities. The Coming Home Program has developed a list in their guide "Developing Affordable Assisted Living in Alaska". There are 23 grant programs and 8 loan programs listed in this guide that provide funding to assist in pre-planning, planning, design and construction of assisted living homes.

In the rural regions of Alaska the three most important sources of funding for both grants and loans are:

Alaska Housing Finance Corporation – In addition to loans, AHFC has several programs that provide grants for pre-development, design, and construction costs. These programs include the GOAL Program (Senior Citizen Housing Development Fund; Special Needs Housing Grant Development Program; Low-Income Housing Tax Credits and HOME funds) and the Assistance Provider Interest Rate Reduction Program.

HUD - This agency has several programs that can be combined to help fund capital costs of assisted living homes. Programs include the: Indian Community Development Block Grant (ICDBG); Indian Housing Block Grant (NAHASDA); Rural Housing and Economic Development Grant; Section 202 Capital Advance Program for the Elderly; Section 232 Elderly Health Care Facilities Loan Guarantee.

USDA Rural Development - This agency has both loan and grant programs that can support assisted living development. These programs include; Rural Business Enterprise Development Grant; Community Facilities Grant; Community Facilities Loan; and Business and Industry Guaranteed Loan Program.

Other Funding Sources - In addition to the major public funding sources above there are a number of smaller public and private funding sources that can and do provide capital support for public and nonprofit assisted living homes. These include the Alaska Mental Health Trust; Rasmuson Foundation, and others. These entities fill a valuable role by providing smaller amounts of capital that often can be used to fill gaps in funding from the larger agencies.

Grant funding for predevelopment is limited. Required predevelopment activities typically include market analysis, needs assessment, site selection and obtaining site control, architectural drawings, preliminary environmental assessments and cost analysis, obtaining community support, developing operational plans, and preparing proposals for capital funding. These predevelopment activities for assisted living are more complex than similar activities for independent housing, and consequently cost more. Alaska Housing Finance Corporation usually offers \$100,000 every two years for predevelopment, with a \$20,000 maximum to any one applicant. This generally is not enough to cover the cost of a market analysis and needs assessment, particularly if an entire region is being studied. Other predevelopment grants offer even less. Costs for predevelopment may vary considerably depending on the numbers of applications for funding required and the requirements of the individual funders.

The development of templates, model business plans, model feasibility analyses, standardized architectural drawings, and other assistance would reduce the cost of predevelopment. The Coming Home Program is working with many partners, both in-state and out-of-state, to develop more sophisticated tools that will take into account

as many relevant factors as possible. These tools will help communities develop realistic plans, and will help funders evaluate proposals properly.

Program Partners

Assisted living is a combination of both housing and health services. Primary responsibility for funding these projects rests with the housing agencies that serve the state of Alaska. Because of its unique character, a combination of housing and health services, the housing agencies have been hesitant to fund rural assisted living. Many funders have looked to the Coming Home Program to provide guidance and leadership for assisted living development. They have actively participated in planning and educational activities. All of the major funders in Alaska, including AHFC, HUD, USDA-RD, AMHTA, Denali Commission, and Rasmuson Foundation, have expressed interest in continuing to work together to develop appropriate state plans and tools which will result in successful projects and ensure that their dollars, when awarded, are spent appropriately. These partners, already on board, will greatly enhance any efforts and capital invested by the Denali Commission.

Although the Denali Commission has a working relationship with HUD and the State (especially the CDBG and ICDBG programs) it has not yet closely associated with the Alaska Housing Finance Corporation. If the Commission determines it wishes to expand its scope to funding capital development of assisted living centers it should develop a closer relationship or partnership with the Alaska Housing Finance Corporation.

Sustainability

One of the primary issues in developing assisted living homes in small rural areas is the sustainability of the facility once it is completed. To be sustainable, the assisted living facility must be able to operate at a reasonable cost (so it must have reasonable economies of scale) and generate sufficient revenues from the fees for services. Residents of an assisted living facility may rely on Medicaid, Public Assistance, Social Security, SSI, and/or rely on private funds for the payment of the costs of the home.

Medicaid CHOICE waivers for Older Alaskans and for Adults with Physical Disabilities provide a substantial portion of the ongoing support for assisted living homes statewide. In March 2003 about 54% of all private assisted living beds were supported by Medicaid waivers. Waivers allow Medicaid funds to be spent on eligible (low-income and nursing home level-of-care) seniors for assisted living services, enabling seniors to avoid the more restrictive and expensive alternative of a nursing home. There are a growing number of assisted living homes that are receiving cost based reimbursement for Medicaid Waiver clients. This funding option is based on actual (or projected) operating costs with a designated allowance for administrative and general costs.

Other Issues

New models are being tested for smaller communities where sustaining an assisted living facility might be more difficult. Port Graham, with funding from the North Pacific Rim Housing Authority (with Denali Commission support), is developing a more flexible elder residential facility offering both independent and supported living. This “mixed use supportive housing” (MUSH) project has received broad support from the community and the regional native entity serving the area. It is unclear at this time where all the resources to sustain and operate this facility will come from and this will certainly have an impact on the level of support services that can be offered to the residents of the facility. The Division of Senior Services is watching this project closely and may, after an opportunity for evaluation, determine that this type of facility is reasonable for very small (Level I and Level II) communities which are not currently a priority for assisted living home development.

Adult day centers are needed in many communities. Adult day centers provide supervised care in a social setting that can include a variety of health and social support services. Centers offer structured activities throughout the day, and attend to clients’ personal care needs. These services are similar to the services provided in assisted living homes. Many adult day participants have family to take care of them during the evenings, nights, and weekends. The adult day center provides a way for family to work outside of the home, while being assured that the senior is being well supervised. A combination of adult day center and assisted living may make sense in some communities.

DOMESTIC VIOLENCE AND SEXUAL ASSAULT

Background

Services for victims of domestic violence and sexual assault first became available in Alaska with the opening in 1977 of the Abused Women's Aid In Crisis (AWAIC) shelter in Anchorage. By 1978 there were services available in eight additional communities, most services were provided through a network of volunteers with some federal funding.

Today, services are available at 23 facilities in 18 communities throughout the state. Twenty-one of these facilities are funded through the Council on Domestic Violence and Sexual Assault (CDVSA). There are an additional two programs that are not funded through the Council; one is funded through a regional Native Corporation (in Kotzebue) and one receives federal money and offers services specifically to Alaska Native Women (in Anchorage).

In 2002 the total number of contacts made at Alaska facilities for victims of domestic violence and sexual assault funded through the Council was 332,775 of which 55,663

Council on Domestic Violence and Sexual Assault FY02 Total Contacts and Shelter Services

Agencies	Total Contacts	Shelter Nights
Abused Women's Aid In Crisis (Anchorage)	53,806	15,514
Advocates for Victims of Violence (Valdez)	3,902	360
Aiding Women from Abuse and Rape Emergencies (Juneau)	40,525	5,413
Alaska Family Resource Center (Palmer)	23,125	3,201
Alaska Women's Resource Center (Anchorage)	3,737	20
Arctic Women In Crisis (Barrow)	8,319	1,300
Bering Sea Women's Group (Nome)	14,473	1,871
Cordova Family Resource Center (Cordova)	409	0
Emmonak Women's Shelter (Emmonak)	2,559	613
Interior Alaska Center for Non-Violent Living (Fairbanks)	18,129	7,894
Kenai/Soldotna Women's Resource and Crisis Center (Kenai)	50,657	6,230
Kodiak Women's Resource and Crisis Center (Kodiak)	3,079	430
Safe and Fear-Free Environment (Dillingham)	33,577	2,163
Seaview Community Services (Seward)	4,153	32
Sitkans Against Family Violence (Sitka)	14,173	3,301
South Peninsula Women's Services (Homer)	10,439	9
Standing Together Against Rape (Anchorage)	15,492	3
Tundra Women's Coalition (Bethel)	5,380	1,854
Unalaskans Against Sexual Assault and Family Violence (Unalaska)	1,162	1,162
Victims For Justice (Anchorage)	2,936	0
Women In Safe Homes (Ketchikan)	22,743	4,293
TOTAL	332,775	55,663

were shelter services (shelter nights). These facilities provide an ever-increasing range of services. Some services provided include; advocacy, legal advice, counseling, residential services, consultation, training, education, prevention and children's services.

Need

The Rasmuson Foundation hired a consultant who completed a statewide facility assessment for the CDVSA. Once the shelters were assessed, the CDSVA worked with Rasmuson Foundation to determine the distribution of \$2,320,000 raised to fund statewide capital improvement projects. These funds include \$1 million from the Rasmuson Foundation, \$500,000 in match to the Rasmuson grant, \$500,000 from the State of Alaska, \$220,000 from the Denali Commission and \$100,000 from Wells Fargo Bank. A total of \$2.32 million has been committed to date.

A list of the currently funded facility upgrades and construction can be found below. In addition to the facilities funded through this initiative, there are two communities (Emmonak and Unalaska) that need new facilities.

Domestic Violence and Sexual Assault Currently Funded Facility Upgrades and Construction

Agency	Community	Cost (\$)
Alaska Family Resource Center	Palmer	534,659
Advocates for Victims of Violence, Inc.	Valdez	15,000
Abused Women's Aid in Crisis, Inc.	Anchorage	401,325
Aiding Women in Abuse and Rape Emergencies	Juneau	87,927
Arctic Women in Crisis	Barrow	86,275
Bering Sea Women's Group	Nome	46,336
Cordova Family Resource Center	Cordova	2,326
Emmonak Women's Shelter	Emmonak	10,087
Interior Alaska Center for Non-Violent Living	Fairbanks	48,340
Kenai Soldotna Women's Resource and Crisis Center	Kenai	125,962
Kodiak Women's Resource and Crisis Center	Kodiak	67,150
Maniilaq Family Crisis Center	Kotzebue	52,300
Safe and Fear-Free Environment, Inc.	Dillingham	75,650
Sitkans Against Family Violence	Sitka	67,070
Seaview Community Services	Seward	86,688
South Peninsula Women's Services	Homer	25,980
Standing Together Against Rape	Anchorage	61,402
Tundra Women's Coalition	Bethel	121,126
Unalaskans Against Sexual Assault and Family Violence	Unalaska	27,459
Women in Safe Homes	Ketchikan	157,566
TOTAL		\$2,100,628

Estimated Costs

The Council on Domestic Violence and Sexual Assault worked with the Rasmuson Foundation to assess facilities statewide and develop a funding strategy that resulted in a \$2.3 million funding package. Funding sources included the Rasmuson Foundation, the State of Alaska, the Denali Commission, and Wells Fargo Bank. The \$2.1 million committed to specific projects so far addressed most of the identified facility needs of agencies funded by the Council on Domestic Violence and Sexual Assault.

New shelters are also needed in Emmonak and Unalaska. However, the costs of these facilities have not yet been determined.

Source of Funding

The Council on Domestic Violence and Sexual Assault has already leveraged a number of sources for facility construction and upgrades. Other sources of funding may include:

HUD - This agency has several programs that can be combined to help fund capital costs of shelters. Programs include the: Indian Community Development Block Grant (ICDBG) and Rural Housing and Economic Development Grant; Section 202 Capital Advance Program for the Elderly.

USDA Rural Development - This agency has both loan and grant programs that can support domestic violence shelter development. These programs include; Rural Business Enterprise Development Grant; Community Facilities Grant; Community Facilities Loan; and Business and Industry Guaranteed Loan Program.

Program Partners

Domestic violence and sexual assault agencies generally partner with many other organizations and state agencies in their communities to assure that there is community response and support for victims. Partners include prosecutors, courts, tribes and local and state law enforcement, as well as other human service providers.

Most domestic violence and sexual assault agencies are freestanding. Two of the exceptions are Seaview Community Services, which also provides mental health, substance abuse and developmental disability services, and the Alaska Women's Resource Center, which also provides substance abuse services. Neither of these agencies provides shelter services.

Sustainability

The services for domestic violence and sexual assault are well supported in all of the communities in which they are located. Local funding sources are generally relied upon to fund facility maintenance and upkeep. Local sources of funding include city or municipal government, Native regional corporations and village councils, United Way, local individual contributions, volunteer time, and in-kind work.

MENTAL HEALTH

Background

The State of Alaska Department of Health and Social Services, Division of Mental Health and Developmental Disabilities (DMHDD) is the primary funder of mental health services in Alaska. Approximately 20,000 people receive treatment and rehabilitative services annually from 46 state grantees. Services provided include general community mental health services; services for youths with serious emotional disturbances; community support for adults with severe mental illness; psychiatric evaluation and treatment for individuals who are mentally ill and involuntarily committed; community based suicide prevention; and peer helpers.

Community mental health centers are located in the following communities:

Aniak	Barrow	Bethel
Fairbanks	Fort Yukon	Galena
Kotzebue	McGrath	Nenana
Nome	Tok	Copper Center
Cordova	Dillingham	East Aleutians
Kenai	Kodiak	Seward
Valdez	Unalaska	Wasilla
West Aleutians/Pribilofs	Craig	Haines
Juneau	Ketchikan	Petersburg
Sitka	Wrangell	

DMHDD provides specialized funding for local community hospitals to care for those in acute psychiatric crisis for whom the array of outpatient and residential emergency services are not adequate. Designated Evaluation and Treatment (DET) programs provide 72-hour psychiatric evaluations and up to 30 days of treatment, and are located in Kodiak, Cordova, Valdez, Juneau, Sitka, Kotzebue, Bethel, and Fairbanks.

Alaska's psychiatric hospital, the Alaska Psychiatric Institute (API), is located in Anchorage and provides inpatient psychiatric care to individuals from all regions of the state. API serves adults and adolescents whose need for psychiatric services exceed the capacity of local service providers. The services provided include comprehensive assessments, physical exams, medical adjustments, stabilization, treatment, and therapy for individuals, groups and/or families. Charter North Hospital in Anchorage is a private sector inpatient psychiatric facility with 74 beds providing services to children and adults.

Need

There is no statewide assessment of need for mental health facility upgrades or construction. Some of the known capital facility needs are reflected in Certificate of Need (CON) letters and applications for inpatient facilities. The table below provides a summary of letters of intent and applications submitted to the Alaska Department of Health and Social Services CON office for the years 2000 through 2002.

Psychiatric Facilities Certificate of Need (CON) Requests and Action

Psychiatric Facility	Request	Action
North Star Behavioral System Wasilla	Construction of a 72 to 90 bed residential facility in Wasilla	Letter of Intent (11/01)
Providence Alaska Medical Center Anchorage	Construction of a 52-bed mental health facility (adults and adolescents)	Approved (3/02)
Alaska Psychiatric Institute Anchorage	Construction of a 72-bed, 80,000 sq. ft. replacement facility	Approved (5/02)

Estimated Costs

The CON process requires that hospitals or organizations submitting applications provide the estimated cost of the project. Any capital project (facilities or equipment) in excess of \$1 million dollars must receive approval through the CON process. In addition, any addition or re-configuration of acute or long-term care beds must receive approval because the changes may impact Medicaid expenditures. The cost of new inpatient psychiatric facilities in Bethel, Nome and Dillingham is unknown. The cost of needed outpatient mental health center/facility upgrades and construction is unknown.

Psychiatric Facility CONs Costs of Facility Upgrades and Construction

Psychiatric Facility	Request	Cost
North Star Behavioral System Wasilla	Construction of a 72 to 90 bed residential facility in Wasilla	Unknown
Providence Alaska Medical Center Anchorage	Construction of a 52-bed mental health facility (adults and adolescents)	\$21.0 million
Alaska Psychiatric Institute Anchorage	Construction of a 72-bed, 80,000 sq. ft. replacement facility	\$41.7 million

Source of Funding

Construction of new inpatient psychiatric facilities will be funded through corporate sources (North Star Behavioral System and Providence Alaska Medical Center) and through state and federal funds (Alaska Psychiatric Institute).

Potential funding sources for outpatient mental health facilities/centers include; Native nonprofits and Indian Health Services as well as the Robert Wood Johnson, Rasmuson Foundation, Annie E. Casey, Regional Native Nonprofits, as well as a number of other private philanthropic organizations. All of these organizations represent funding sources that could be coupled with Denali Commission funding or stand-alone.

Other sources include:

HUD - This agency has several programs that can be combined to help fund capital costs of assisted living homes. Programs include the: Indian Community Development Block Grant (ICDBG); Indian Housing Block Grant (NAHASDA); Rural Housing and Economic Development Grant; Section 202 Capital Advance Program for the Elderly; Section 232 Elderly Health Care Facilities Loan Guarantee.

USDA Rural Development - This agency has both loan and grant programs that can support mental health facility development. These programs include; Rural Business Enterprise Development Grant; Community Facilities Grant; Community Facilities Loan; and Business and Industry Guaranteed Loan Program.

Program Partners

Community mental health services can be integrated with a number of services, including primary care clinics, public health nursing, public safety, substance abuse programs and others, depending on the community. Galena has co-located their health clinic, behavioral health, city offices and community center. The Copper River Native Association has behavioral health, social services and nutrition programs under one roof. These agencies have demonstrated that sharing facilities can reduce program overhead and clients/patients find having all services in one place more convenient.

Sustainability

Mental health services are generally supported through client payments, state grants and Medicaid and should be adequate to sustain operations of any new facilities planned.

Other issues

There is a lack of a residence behavioral health facility for children anywhere in Alaska. It is reported by the DHSS that up to 130 Alaska children are sent outside annually for treatment services at a cost to the State of Alaska of \$7 Million annually.

SUBSTANCE ABUSE

Background

There are 92 state approved alcoholism and drug abuse programs in 45 communities throughout Alaska. Although there is a substance abuse program in every region of the state, there are often waitlists to receive program services. Programs provide information, education, outpatient counseling, residential treatment, emergency care, and relapse prevention services.

Many studies have shown that alcohol abuse is one of the most devastating social problems in rural Alaska. Alaska Natives make up only 17 percent of the state population but they make up 38 percent of those who die by suicide. Approximately, 2/3 to 3/4 of suicides involving Alaska Native people also involve the use of alcohol. The Division of Alcohol and Drug Abuse published a needs assessment of substance abuse treatment called *An Integrated Substance Abuse Treatment Needs Assessment for Alaska* (ISATNA). The report identifies the need for additional treatment capacity in Alaska.

Key informants indicate that there is high demand for treatment facilities all over the state. Wait-listing potential recipients of substance abuse treatment can have dire effects as the window of opportunity with many people who are dependant on drugs and alcohol is very small. This is especially the case for children with behavioral health problems. There are few residential programs for children who need mental health and/or substance abuse services. Up to 130 Native Alaskan children are sent to other states to receive treatment each year at a cost of \$7 Million annually to the State of Alaska.

The appropriate level of care is critical to successful outcomes. If the appropriate level of care is unavailable, the person may not be able to successfully address their substance abuse disorder. If a person needs an intensive level of care that is not available in the community in which they reside, and access elsewhere is limited due to prohibitive costs, the condition may deteriorate into an emergency. At that point treatment is significantly more costly than if it occurred earlier.

Need

The most comprehensive source of information regarding the demand for, and availability of, substance abuse treatment facilities in Alaska is the ISATNA report published by the Division of Alcohol and Drug Abuse. According to the ISATNA report there were 38,790 people, or 6.2% of the total population of Alaska, in need of substance abuse treatment services.

It is estimated that only 2.6% of those in need of treatment are homeless or incarcerated. While these two sub-groups have a relatively high rate of substance abuse they represent a very small portion of the overall population.

Integrated Substance Abuse Treatment Needs Assessment for Alaska
Substance Use Disorder Prevalence Estimates

Survey Group	Alaska Population	Prevalence Estimate (%)	Number in Need of Treatment	Proportion of Treatment Need (%)
Adults in Households with Telephones (ages 18 and older)	401,874	7.4	29,739	76.7
Persons 12 and Older in Households Without Telephones	28,205	15.8	4,456	11.5
Adolescents (ages 12-17 in Households with Telephones)	64,748	5.5	3,561	9.2
Recently Incarcerated Prisoners (ages 18 and older)	610	79.0	482	1.3
Homeless (all ages excluding children accompanied by an adult)	988	47.0	464	1.2
Adolescents in Correctional Facilities	142	79.0	88	0.1
Total	496,567	7.8	38,790	100.0

The need for treatment was defined in the ISATNA report as a person that has had a substance use disorder within the last year.

Integrated Substance Abuse Treatment Needs Assessment for Alaska
Recommended Additional Treatment Capacity

Region	New Admissions
Northcentral	108
Yukon Delta	184
Kenai Peninsula, Prince William Sound, Copper River, Kodiak	283
Bristol Bay, Aleutians	55
Southcentral	496
Central	5
Northwest	4
Southeast	0
North Slope	0
TOTAL	1,131

Data analysis indicated that of the 38,790 people in need of treatment 5,039 actually received treatment services. However, it is clear that not all of the 38,790 people who needed treatment would have sought it even if it were readily available. The ISATNA report estimates that there were 1,131 people in Alaska who were in need of treatment, sought treatment and were unable to receive treatment. The report recommends that the State increase services by 18.9%. In the year 2000 approximately one in every 6.5 people needing treatment obtained it. The report also suggests that Alaska should consider how to increase the proportion of people in need who seek out treatment.

Estimated Costs

There are no estimates for cost available.

Source of Funding

HUD - This agency has several programs that can be combined to help fund capital costs of substance abuse facilities. Programs include the: Indian Community Development Block Grant (ICDBG); Indian Housing Block Grant (NAHASDA); Rural Housing and Economic Development Grant; Section 202 Capital Advance Program for the Elderly; Section 232 Elderly Health Care Facilities Loan Guarantee.

USDA Rural Development - This agency has both loan and grant programs that can support substance abuse facilities. These programs include; Rural Business Enterprise Development Grant; Community Facilities Grant; Community Facilities Loan; and Business and Industry Guaranteed Loan Program.

Other sources of funding include; Grants from the Division of Alcohol and Drug Abuse, Medicaid, private insurance, private pay, Native nonprofits and Indian Health Services as well as the Robert Wood Johnson, Rasmuson Foundation, Annie E Casey, Regional Native Nonprofits, as well as a number of other private philanthropic organizations. These all represent funding sources that can be coupled with Denali Commission funding or stand-alone.

Program Partners

Drug and Alcohol Treatment facilities administered through the Division of Alcohol and Drug Addiction partner with a wide variety of private sector companies in the delivery of services. Many facilities partner with Native nonprofits, private nonprofits, mental health practitioners and the Department of Corrections. In some rural communities, facilities space is so scarce that some non-traditional partnering has occurred.

One example of such a partnership is in Dillingham where there is no residential substance abuse treatment program for women with children. The organization that provides substance abuse treatment in Dillingham has partnered with the women's shelter there to allow women with children to receive residential treatment services without being forced to leave the community.

Partners not only save money but also bring together service providers that may be providing different services to the same person. Key informants indicate that partnering enhances services delivery and expands access to support services. There is a nationwide movement to combine delivery of substance abuse and mental health treatment services with primary care services in order to provide more cohesive and holistic treatment services.

There are several examples of problems that might be solved by combining substance abuse, mental health and primary care services. One such problem is that providers of substance abuse treatment are required to do a medical screen of all new clients, they are mostly screening questions but if a person comes in who has not been screened they may be referred to a doctor to get the medical screening done. Sometimes referring a person to a doctor is problematic because people seeking services often do not have adequate funds or the health insurance necessary to see a doctor. They may also lose interest in receiving treatment if the process seems too cumbersome. Many people feel that there is a natural partnership between primary care and chemical dependency and mental health treatment.

Sustainability

There are several sources of funding for the treatment of individuals in rural Alaska. Treatment providers must be wary of overbuilding and crippling their ability to maintain operations over time. Some sources of funding for substance abuse treatment facilities include; grants from the Division of Alcohol and Drug Abuse, Medicaid, private insurance, private pay, Native nonprofits and Indian Health Services.

Some new sources of funding may become available with the increase in the state excise tax on alcoholic beverages that went into effect October 2002. Half of the receipts from that tax may be directed toward alcohol prevention and treatment programs. Supporters of the tax increase effort have forwarded recommendations to the new Gubernatorial administration that would substantially increase both capital and treatment dollars available for substance abuse treatment in Alaska. At this time there is no indication from the administration of the fate of these requests.

Other Issues

There is a particularly high need for treatment services for Alaska Native people. It is estimated that 17.9% of the Alaska native population age 18 and older have a

substance use disorder. Most of the research suggests that the majority of Alaska Native people with substance abuse disorders are struggling with alcohol but that other illicit narcotics are growing in popularity. Alaska Native people represented roughly 17% of the state population in 1999 but 35% of the prison population.

FOOD BANKS AND PANTRIES

Background

One in five children and one in ten adults in Alaska are at risk of going to bed hungry every day. Alaska has one statewide food bank in Anchorage, five community food banks and approximately 270 food pantries that collect and distribute food to people in need. Food banks are collection points for food contributed by local communities or provided by the federal government. Food banks provide food to food pantries, which are community agencies, churches and other distribution points where people can come to pick up food boxes.

The Food Bank of Alaska in Anchorage obtains and distributes food statewide to nonprofit agencies serving hungry people. Last year, they distributed more than 3 million pounds - more than 2 million meals - to 270 partner agencies throughout the state. There are community food banks in Anchorage, Fairbanks, Juneau, Kenai, Kodiak and Nome, all of which work with food pantries in their communities to distribute food boxes. Food pantries are located in the following communities:

Alakanuk	Homer	Ninilchik	Shishmaref
Anchor Point	Hoonah	Nome	Sitka
Anchorage	Houston	North Pole	Soldotna
Barrow	Juneau	Nuiqsut	Stebbins
Bethel	Kake	Palmer	Sterling
Brevig Mission	Kenai	Petersburg	Stony River
Chitina	Klawock	Point Hope	Teller
Copper Center	Kodiak	Point Lay	Trapper Creek
Cordova	Kotlik	Port Heiden	Two Rivers
Delta Junction	Koyuk	Saint George	Valdez
Dillingham	Metlakatla	Saint Michael	Wales
Elim	Mountain Village	Salcha	Wasilla
Eyak	Naknek	Sand Point	Willow
Fairbanks	Nikiski	Seward	Sitka

Sources of food include local super markets, gardeners, hunters, and canned food drives. Food banks receive most of their financial support from local sources, in particular from local United Way agencies. They also receive some state and federal support.

Need

There is no statewide assessment of need for food bank upgrades or construction. Most of the known capital need is for equipment such as freezers and vans. Four

years ago, the Fairbanks Community Food Bank moved into a new multi-purpose facility that was financed and built by a local benefactor.

Estimated Costs

The cost of needed food bank facility upgrades and construction is unknown.

Source of Funding

The Food Bank of Alaska is in the early stages of discussions with the U.S. Department of Agriculture for Rural Development grant funding. Other potential sources of funding include local fund raising, the Rasmuson Foundation, the Denali Commission, volunteer or in-kind labor or materials. Other sources of funding may include the HUD Indian Community Development Block Grant (ICDBG).

Program Partners

Some of the agencies that food banks might form partnerships or co-locate with are the Salvation Army, the Food Stamp program, WIC, school lunch and nutrition programs, domestic violence shelters, general social services shelters and health centers. The Fairbanks Community Food Bank also houses WIC cooking classes, an alternative high school, and provides conference room meeting space to a variety of community organizations.

Sustainability

Food banks rely heavily on community financial and volunteer support. Food bank services and facility maintenance costs are dependent on continuous fund raising and calls for community support. Because there are so few outside sources, food banks are less affected by fluctuations in state and federal funding but must be able to generate energy and good will in the community to continue operations.

EARLY CHILDHOOD SERVICES

Background

Head Start

Head Start is a comprehensive early childhood education program serving low-income children between the ages of 3 and 5 years (and Early Head Start serving birth to 3 year olds) and their families in 101 communities throughout the state. The program offers developmentally and culturally appropriate early childhood education, health, nutrition, social services, parent involvement and career development. In FY02, there were 3,420 children participating in Head Start in Alaska.

Head Start operations are federally and state funded. Costs covered under these funds include: staff wages, staff training, health services, supplies and equipment as well as expansion of these services. Federal Region X funds a portion of the Alaska programs, as does Region XI, which is the American Indian/Alaska Native Programs Branch. State funds contribute to the non-federal required 20% match of each Head Start grantee. Programs in Alaska are administered from Anchorage and are subject to annual government appropriations.

Childcare

Approximately 68% of Alaska's children under 6 years old have working parents. Many of these children are cared for by one of nearly 2,200 childcare providers, either in childcare centers or in family childcare homes or group homes. Most childcare centers are located in Alaska's larger communities. Childcare in rural areas is almost always provided in family childcare homes.

The Alaska Department of Education and Early Development is responsible for licensing childcare centers and homes and administers the state's childcare assistance programs. Regional resource and referral agencies, located in Anchorage, Fairbanks and Juneau, assist families in locating childcare and provide ongoing training opportunities for childcare providers.

Alaska Childcare Providers

Licensed/Regulated Childcare	Number
Childcare Centers (2002)	230
Family Childcare Homes (2001)	1,915
Family Childcare Group Homes (2001)	47
TOTAL	2,192

Need

There is no statewide assessment of need for childcare facility upgrades or construction.

Estimated Costs

The cost of needed childcare facility upgrades and construction is unknown.

Source of Funding

Potential sources of funding for childcare facility upgrades and construction include the Rasmuson Foundation, local fund raising, volunteer or in-kind labor or materials. Other sources of funding may include:

HUD - This agency has several programs that can be combined to help fund capital costs of shelters. Programs include the: Indian Community Development Block Grant (ICDBG) and Rural Housing and Economic Development Grant. One childcare center is currently receiving HUD matching funds.

USDA Rural Development - This agency has both loan and grant programs that can support domestic violence shelter development. These programs include: Rural Business Enterprise Development Grant; Community Facilities Grant; Community Facilities Loan; and Business and Industry Guaranteed Loan Program.

Program Partners

Childcare centers are generally located in larger communities and most are single purpose facilities. There are some employer sponsored childcare centers in the state's largest communities that are provided on the worksite. Hospitals, native corporations and the military are most likely to provide employer-sponsored childcare.

Sustainability

Funds for program expenses are expected to continue at current levels. Childcare is paid for by parents and employers. The federal government is the main source of funding for Head Start services. Most early childhood programs are currently paying rent, which includes facility maintenance costs.

RURAL LEARNING CENTERS

Background

Rural Learning Centers provide support for students of rural campuses through the University of Alaska. Facility type is important because university learning centers have to be equipped with a variety of technology to facilitate rural distance education. Centers need to have audio-conferencing capabilities, computers and Internet access at the very least. Internet connectivity and access to computers is an essential component to successful completion of distance education courses, in many rural communities within Alaska Internet access is cost prohibitive. Learning centers also provide a quiet environment away from home where students are able to focus all of their attention on learning.

The University of Alaska has branch-learning centers in Fort Yukon, McGrath, Galena, Tok and Unalaska. The Dillingham Campus has learning centers in King Salmon and Togiak.

The University of Alaska has vocational learning centers in both Kotzebue and King Salmon with one slated to be built in Bethel. The College of Rural Alaska served an estimated 5,018 students in the spring of 2000.

Rural Learning Centers
College of Rural Alaska Student Headcount by Campus

Campus	# Students
Bristol Bay Campus	596
Chukchi Campus	230
Interior/Aleutians Campus	574
Kuskokwim Campus	366
Northwest Campus	476
Rural College Campus	904
Tanana Valley Campus (Fairbanks)	2,474
TOTAL	5,018
Total without Tanana Valley Campus	2,842

The University of Alaska is the only institution that offers degree programs in Alaska. There are however, other organizations that provide similar services outside of outside of the degree programs.

The Cooperative Extension Service offers access to computers and the Internet as well as some career and education advising, they do not offer a classroom setting. The Cooperative Extension Service has offices in the following 12 communities in Alaska:

- Anchorage
- Bethel
- Delta Junction
- Eielson Air Force Base
- Fairbanks
- Juneau
- Kodiak
- Nome
- Palmer
- Sitka
- Soldotna/Kenai
- Thorne Bay

There are also Native nonprofit that provide learning centers. These learning centers more often offer adult education programs like GED training and career skills.

Need

Communities with identified need are:

- Saint Mary's under the Bethel Campus has secured funding to build a learning center.
- Aniak under the Bethel Campus is in need of a learning center but has not yet secured funding.
- Fort Yukon is currently \$1.8 million over-budget on the learning center project that is currently underway there. Fort Yukon has not yet secured the additional \$1.8 million necessary to complete the project.
- The Kuskokwim Campus is interested in expanding their facilities but have not yet secured funding.

The College of Rural Alaska is in the process of doing a comprehensive assessment of current facilities as part of an overall facilities plan for rural Alaska. There is also a planned assessment regarding para-educator certificate need programs that is mandated under the "No Child Left Behind Law". Plans for the para-educator needs assessment will go before the Board of Regents in April.

There are some project prioritization methodologies currently employed by the College of Rural Alaska. A big part of that prioritization methodology is to first get an assessment of existing facilities done so that a plan can be formed. After the facilities plan is done the directors of all the rural campuses will sit down and prioritize projects according to greatest need. The projects will then have to be sent

through university channels to become part of University of Alaska's master plan. Rural campuses and learning centers are not currently part of the master plan, doing the facilities plan will get them on the capital list.

Key informants indicate that there is definitely a need for additional rural learning centers but the university is carefully planning so as not to duplicate efforts. The providers of vocational and technical education are currently holding meetings on how to better coordinate and deliver services in rural Alaska.

Estimated Costs

There is not currently a comprehensive estimate of need or associated cost. The Nome campus has completed assessment of their facilities and estimate a minimum cost of \$4.8 million in 2002 dollars to update their facilities.

Source of Funding

State Appropriations – College of Rural Alaska as part of the University of Alaska gets state appropriations from the general fund through as determined by the legislature.

US Department of Education Title III – Title III funds are available for rural learning centers because they provide services to primarily non-white students.

HUD - This agency has several programs that can be combined to help fund capital costs of rural learning centers. Programs include the: Indian Community Development Block Grant (ICDBG); Indian Housing Block Grant (NAHASDA); Rural Housing and Economic Development Grant; Section 202 Capital Advance Program for the Elderly; Section 232 Elderly Health Care Facilities Loan Guarantee.

USDA Rural Development - This agency has both loan and grant programs that can support rural learning centers. These programs include; Rural Business Enterprise Development Grant; Community Facilities Grant; Community Facilities Loan; and Business and Industry Guaranteed Loan Program.

Alaska Housing Finance Corporation – AHFC offers a variety of low interest loan programs that can be used in combination with traditional bank loans and other funding sources to provide capital funding.

Program Partners

The College of Rural Alaska is interested and actively pursues partnership with any organization that operates in rural Alaska. Partnerships provide opportunities for cost

sharing, information sharing and workforce development. Rural campuses are there to meet the needs of the community in which they operate. They achieve this goal by offering degree programs, career and workforce development, as well as special topic courses by request.

Native nonprofits are key partners in terms of co-sponsoring courses and providing some learning center facilities. They are also partners in offering some courses, such as medical billing and nursing. The Yukon-Kuskokwim Health Corporation provides space and expertise in offering courses in the health care profession.

Other examples of community partnership include:

- Community Development Quota (CDQ) programs offer scholarships and internships.
- In Galena the rural learning center is co-located with the charter school.
- In Togiak the learning center is co-located with the Youth Opportunity Program, which is funded by the Alaska Federation of Natives.
- In King Salmon the rural learning center is located in city office space.

Sustainability

For rural learning centers the College of Rural Alaska gets the majority of its funding through Fairbanks Native Association (FNA) indirect funds. They get a base of money every year out of the General Fund (GF) and then the FNA indirect funds fill the gaps.

Rural campuses throughout the state have also done a great job of bringing in grants independently. Since rural learning centers are all minority-serving institutions they are eligible for federal set-asides from the National Science Foundation, HUD and USDA. There are other federal sources that have not yet been utilized such as federal set-asides from the National Oceanic and Atmospheric Association and NASA.

APPENDICES

Appendix A

Comparison of Actual Costs to Estimate Cost for Primary Care Centers Construction Awards in FY 2001 and FY2002*

Community	Alaska Primary Care Feasibility Study	Projects in Construction Jan 2003	
	Total Unmet Need	Total Project Costs	Denali Commission Share for
Akutan	\$ 882,358	\$ 601,431	\$ 277,258
Alatna	\$ 521,929	\$ 1,696,000	\$ 291,000
Aniak	\$ 1,414,135	\$ 1,420,853	\$ 1,420,853
Egegik	\$ 692,149	\$ 509,591	\$ 246,543
Emmonak	\$ 817,487	\$ 110,810	\$ 55,310
	\$ 664,645	\$ 104,399	\$ 104,399
Galena	\$ 298,857	\$ 1,800,000	\$ 3,795,000
Haines	\$ 1,880,731	\$ 1,733,100	\$ 1,420,480
Iliamna	\$ 432,674	\$ 4,594,039	\$ 3,586,383
Kiana	\$ 676,298	\$ 1,116,100	\$ 716,100
King Cove	\$ 855,703	\$ 4,135,000	\$ 2,500,000
Klawock	\$ 2,374,567	\$ 2,616,855	\$ 1,797,298
Newtok	\$ 877,074	\$ 428,432	\$ 428,432
Nightmute	\$ 877,074	\$ 960,405	\$ 317,889
Noatak	\$ 887,641	\$ 739,031	\$ 739,031
Nulato	\$ 676,298	\$ 671,411	\$ 671,411
Nunam Iqua	\$ 882,358	\$ 999,315	\$ 804,430
Pilot Station	\$ 693,299	\$ 643,848	\$ 643,848
Russian Mission	\$ 676,298	\$ 655,641	\$ 655,641
Saint Mary's	\$ 424,742	\$ 3,900,000	\$ 250,000
Saint Michael	\$ 702,716	\$ 304,000	\$ 304,000
Savoonga	\$ 1,058,198	\$ 285,000	\$ 285,000
Scammon Bay	\$ 719,651	\$ 575,000	\$ 257,000
Shageluk	\$ 887,641	\$ 855,443	\$ 670,400
Shungnak	\$ 887,641	\$ 739,031	\$ 739,031
Sleetmute	\$ 877,074	\$ 785,639	\$ 785,639
Talkeetna	\$ 1,020,058	\$ 4,669,470	\$ 3,820,470
Unalakleet	\$ 1,258,857	\$ 8,200,000	\$ 3,150,000
Wales	\$ 903,492	\$ 355,000	\$ 355,000
SUBTOTAL	\$ 25,821,647	\$ 46,204,844	\$ 31,087,846
TOTAL PROJECT COSTS AS A PERCENT OF ESTIMATED COSTS			%179

*Excludes projects not included in the needs assessment. (Fireweed Clinic and Interior Neighborhood Health Center)

Source: Alaska Rural Primary Care Facility Needs Assessment Data base, 2000
Denali Commission Project Data Base, January 2003-

Appendix B

Comparison of Estimated Costs to Actual Costs - Small Clinic Primary Care Facilities Scheduled for Construction FY2003

Community	Current Costs Estimate of Project	Required Match	Total Community Required Share	Alaska Primary Care Needs Assessment – Estimated Costs	Denali Commission Share for Projects in Construction Jan 2003
Akhiok	\$690,000	50%	\$345,000	\$692,148	(\$2,148)
Arctic Village	\$878,000	20%	\$175,600	\$686,865	\$191,135
Atka	\$684,000	50%	\$342,000	\$692,149	(\$8,149)
Birch Creek	\$658,500	20%	\$131,700	\$469,652	\$188,848
Chalkyitsik	\$878,000	20%	\$175,600	\$686,865	\$191,135
Chenega Bay	\$520,500	50%	\$260,250	\$534,162	(\$13,662)
Chignik Lake	\$888,000	50%	\$444,000	\$692,149	\$195,851
Chitina	\$678,000	50%	\$339,000	\$877,074	(\$199,074)
Circle	\$545,805	20%	\$109,161	\$497,464	\$48,341
Copper Center	\$600,000	50%	\$300,000	\$790,383	(\$190,383)
Ekwok	\$700,000	20%	\$140,000	\$692,149	\$7,851
Evansville	\$648,000	50%	\$324,000	\$521,929	\$126,071
Golovin	\$903,006	50%	\$451,503	\$877,641	\$25,365
Goodnews Bay	\$900,000	20%	\$180,000	\$612,497	\$287,503
Hughes	\$579,000	20%	\$115,800	\$415,299	\$163,701
Huslia	\$866,000	20%	\$173,200	\$676,398	\$189,602
Kaltag	\$772,000	20%	\$154,400	\$662,374	\$109,626
Karluk	\$520,500	50%	\$260,250	\$686,865	(\$166,365)
Kokhanok	\$690,000	20%	\$138,000	\$686,865	\$3,135
Koliganek	\$896,000	20%	\$179,200	\$877,074	\$18,926
Koyukuk	\$674,271	20%	\$134,854	\$887,641	(\$213,370)
Levelock	\$690,000	50%	\$345,000	\$686,865	\$3,135
Little Diomede	\$700,000	20%	\$140,000	\$557,632	\$142,368
Manokotak	\$896,000	20%	\$179,200	\$877,074	\$18,926
Mekoryuk	\$902,000	20%	\$180,400	\$877,074	\$24,926
Minto	\$864,000	20%	\$172,800	\$676,298	\$187,702
Nikoli	\$746,000	20%	\$149,200	\$649,880	\$96,120
Perryville	\$878,000	50%	\$439,000	\$681,582	\$196,418
Platinum	\$675,000	20%	\$135,000	\$676,877	(\$1,877)
Stevens Village	\$657,000	20%	\$131,400	\$530,085	\$126,915
Takotna	\$668,000	50%	\$334,000	\$525,647	\$142,353
Teller	\$903,006	20%	\$180,601	\$887,641	\$15,365
Twin Hills	\$517,500	50%	\$258,750	\$530,085	(\$12,585)
Tyonek	\$684,000	50%	\$342,000	\$686,865	(\$2,865)
Venetie	\$866,000	20%	\$173,200	\$676,298	\$189,702
White Mountain	\$903,006	20%	\$180,601	\$767,683	\$135,323
TOTAL	\$26,719,094		\$8,214,671	\$24,503,232	\$2,215,862
PROJECT COSTS AS A PERCENT OF ESTIMATED COSTS				109%	

APPENDIX C

Consolidated Interviews

List of known facilities: Inadequacies

Hospitals: Acute Care: Lorraine Derr

Alaska Psychiatric Institute, Anchorage
Alaska Native Medical, Anchorage
Alaska Regional, Anchorage
Bartlett, Juneau
Bassett Army, Ft Wainwright
Central Peninsula, Soldotna
Cordova Community Medical Center, Cordova
Fairbanks Memorial, Fairbanks
Kanakanak, Dillingham
Ketchikan Medical Center. Ketchikan
Maniilaq, Kotzebue
Mt. Edgecumbe, Sitka
North Star Behavioral, Anchorage
Petersburg Hospital, Petersburg
Providence, Anchorage
Providence, Kodiak
Providence, Seward
Providence, Sitka
South Peninsula, Homer
Elmendorf Hospital, Elmendorf Air Force Base
Samuel Simmons, Barrow
Norton Sound, Nome
Valdez Hospital, Valdez
Valley Hospital, Palmer
Wrangell Hospital, Wrangell
Yukon-Kuskokwim Delta, Bethel

Inadequacies: Bethel, Nome, Kotzebue, and Dillingham.

Hospitals: Primary Care: Rick Boyce

IHS has a facility replacement list for replacement facilities that will receive full funding from the agency
Barrow Hospital
Nome Hospital
Bethel Quarters
Metlakatla Clinic
St. Paul Clinics

For each of the above facilities there is a detailed POR/PJD defining the program to be in the facility and the costs of replacement – total replacement costs for above facilities are over \$250 million dollars.

His office is also completing a statewide needs assessment of dental facilities for tribal programs. The draft will be ready for public review in one week.

Mr. Boyce is currently doing a statewide master plan for the IHS funded services. It will identify where service are currently provided, referral patterns and deficiencies. The plan will also identify the facility needs and the costs of the facility needs for the state. This service delivery component of the plan will be finished in early fall 2003, the facility need component in spring 2004. The state is updating the health facilities plan that will complete in January 2004.

Nursing Homes: Lorraine Derr

Most hospitals have nursing homes associated with them.

The stand-alone facilities are:

Denali Center in Fairbanks

Heritage Place in Soldotna

Mary Conrad Center in Anchorage

Providence Extended Care in Anchorage

Wildflower Court in Juneau

Inadequacies: There are places like Glenallen and out on the Aleutian Chain where there are no hospitals but it is not necessarily a major problem because people who live in these places can fly into other communities to receive services. There are a lot of places that would like to have more clinics, but we are not looking at opening new hospitals anywhere.

Dental Services: Mary Elizabeth Rider

In Dental Facility Needs report there is a list of organizations and the communities they serve. The term facility can be misleading when it comes to dentists because “facility” can be anywhere that the dentist is able set up their equipment. There are some villages that have permanent dental operatory sites but almost none that have a permanent dentist or dental hygienists.

Assisted Living: Kay Branch and Patricia Atkinson

Name of Home	Location	# of Beds
Utuqqanaqagvik (Senior Citizens Program)	Barrow	11
Anchorage Pioneer Home	Anchorage	228
Fairbanks Pioneer Home	Fairbanks	101
Juneau Pioneer Home	Juneau	48
Sitka Pioneer Home	Sitka	102
Ketchikan Pioneer Home	Ketchikan	47
Palmer Pioneer Home	Palmer	82
Kotzebue Cultural Center	Kotzebue	20
Regional Elders Residence	Tanana	14
Marrulut Eniit Assisted Living (MEAL)	Dillingham	15
Chugiak Senior Citizens	Chugiak	30
Friendship Terrace	Homer	40
Salmonberry Village	Juneau	11
Horizon House (Including Ed's Place)	Anchorage	87
Marlow Manor	Anchorage	54
Bayview Terrace	Kodiak	20
59 small homes (2-5 beds)	Anchorage/E. R./Chugiak	259
11 larger homes (6-16 beds)	Anchorage	94
16 small homes (2-5 beds)	Fairbanks/North Pole	76
2 larger homes (8-14 beds)	Fairbanks	22
9 small homes (2-5 beds)	Kenai Peninsula	34
3 larger homes (6-8 beds)	Kenai Peninsula	22
2 small homes (5 beds)	Juneau	10
1 larger home (11 beds)	Ketchikan	11
15 small homes (2-5 beds)	Palmer/Wasilla	58
3 larger homes (10-11 beds)	Palmer/Wasilla	31

Community	# Homes	% Total	# Beds	% of Total
Anchorage	74	54%	752	49%
Fairbanks	19	14%	199	13%
Palmer Wasilla	19	14%	171	11%
Kenai Peninsula	13	9%	96	6%
Juneau, Ketchikan, Sitka	7	5%	229	15%
Other	5	4%	80	5%
TOTAL	137		1,527	

Food Banks and Pantries: Susannah Morgan

Food Bank of Alaska partners with over 270 nonprofits to provide services.

1st Independent Samoan Assembly of God	Naqragmiut Tribal Council
1st Samoan Stand-by Faith Church	Native Council of Port Heiden
1st Samoan Star of the Bright	Native Village of Eyak
Abbott Loop Community Church	Native Village of Koyuk
Akeela House	Native Village of Point Hope
Alaska Baptist Family Center	Native Village of Shishmaref
Alaska Women's Resource Center	Native Village of St. Michael
Alaska Youth & Parent Foundation	Native Village of Wales
Alaskan Aids Assistance Association	New Hope on the Last Frontier
Alpine Alternatives	Nome Community Center
Anchorage Community SDA Church	North Anchorage Church of God
Anchorage Community YMCA	Nuiqsut Assembly of God Church
Anchorage Free Methodist Church	Nunakauyak Traditional Council
Anchorage Mutual Housing	Our Lady of the Lake Food Pantry
Anchor Age Senior Center	Palmer Food Bank
AVAIL	Palmer Senior Center
AWAIC	Providence Extended Care
Beans Cafe	Quyana House
Bethel Lions Club	Resurrection Bay Lions Club
Big Dipper Community Circle	Robertson Enterprises - Carousel Day Care Center
Boys & Girls Club	Robertson Enterprises - Gingerbread Day Care Center
Bristol Bay Native Association	Roger Holmberg Evangelistic Association
Brevig Mission Food Bank	RuralCAP - Child Development Center
Burchell High School	RuralCAP - Homeward Bound
Campfire Boys & Girls Alaska Council	Salvation Army Adult Rehab Program
Challenge Alaska	Salvation Army Booth Memorial
Christian Pilots Association of Alaska	Salvation Army Family Emergency Services
Chugiak Senior Center	Salvation Army Homer
Chugiak/Eagle River Food Pantry	Salvation Army Hoonah
City of Alakanuk	Salvation Army Juneau
Cook Inlet Tribal Council (ANARC)	Salvation Army Kake
Copper River Native Association	Salvation Army Kenai Peninsula
Covenant House	Salvation Army Klawock
CSS-St. Francis House	Salvation Army Mat Su Valley Corps.
Dena A. Coy	Salvation Army McKinnell Shelter
Dimond Jewel Church of God	Salvation Army Metlakatla
Eagle River Church of God	Salvation Army Older Alaskans Program
Elmendorf AFB Chapel	Salvation Army Petersburg
Fairbanks Community Food Bank	Salvation Army Serendipity Adult Day Service
Faith Daycare & Learning Center	Salvation Army Sitka
Family Christian Center	SCC Annex
Family Food Cache	SCC Continued Care Unit/Crossover
First Bible Baptist Church of Point Lay	SEARCH-CHSD
FISH	Service Adventure
Food Pantry of Wasilla	Special Olympics Alaska
Genesis House	Spenard Kiddy Drop
Hilltop Assembly of God	Spenard Lions Club
Hope Christian Fellowship	St. Christopher's Episcopal Church
Kenai Peninsula Food Bank	St. George Traditional Council
Kids Are People. Inc.	

Kids First Early Learning Center
King's Kids Child Care
Kodiak Island Food Bank
Kotlik Traditional Council
Latino Lions
Lions Club of Barrow
Little Beaver Camp
Lutheran Social Services of Alaska
Mid Valley Seniors
MLK/Shiloh Foundation
Mt. View Baptist Church
Naknek Native Village Council

STA Traditional Food Program
Stebbins Community Association
Stony River Traditional Council
Store House Ministries
Teen Challenge - Women's Center
Teen Challenge of Alaska
Trapper Creek Food Bank
Valdez Food Bank
Volunteers of America-ARCH
Wasilla Area Seniors
Willow Area Seniors

Childcare

State website for licensed childcare is most complete.

Head Start: Claudia Shanley

Head Start is in 101 communities statewide.

Substance Abuse: Pam Watts

This information is in the State of Alaska Directory of Approved Alcoholism and Drug Abuse Programs published by the Division of Alcohol and Drug Abuse.

Inadequacies: Pretty much all over the state. We have a shortage of available treatment for people with substance abuse disorders. Sometimes people are on such long waitlists that they disappear or start using again before they are able to get into a treatment facility. The window of opportunity is lost. Pretty much all facilities statewide are busy.

Mental Health: Jeff Jessee

No answer given.

Domestic Violence: Susan Scudder

Advocates for Victims of Violence (AVV) – Valdez
Emmonak Women's Shelter (EWS) – Emmonak
South Peninsula Women's Services (SPWS) – Homer
Abused Women's Aid In Crisis (AWAIC) – Anchorage
Interior Alaska Center for Non-Violent Living (IAC) – Fairbanks
Standing Together Against Rape (STAR) – Anchorage
Aiding Women from Abuse and Rape Emergencies (AWARE) – Juneau
Kenai/Soldotna Women's Resource and Crisis Center (K/SWRCC) – Kenai
Tundra Women's Coalition (TWC) – Bethel
Arctic Women In Crisis (AWIC) – Barrow
Kodiak Women's Resource and Crisis Center (KWRCC) – Kodiak
Unalaskans Against Sexual Assault and Family Violence (USAFV) – Unalaska
Alaska Women's Resource Center (AWRC) - Anchorage
Safe and Fear-Free Environment (SAFE) – Dillingham

Victims For Justice (VFJ) – Anchorage
Bering Sea Women’s Group (BSWG) – Nome
Sitkans Against Family Violence (SAFV) – Sitka
Alaska Family Resource Center (AFRC) – Palmer
Cordova Family Resource Center (CFRC) – Cordova
Seaview Community Services (SCS) – Seward
Women In Safe Homes (WISH) – Ketchikan

Rural Learning Centers: Bernice Joseph

Branch Learning Centers in:

Fort Yukon
McGrath
Galena
Tok
Unalaska

Dillingham Campus

King Salmon Center
Togiak Center

Bethel Campus

Saint Mary’s (have funding secured and is being built)
Aniak (would like to build but have not yet secured funding)

Vocational Learning Centers

Bethel (funding secured, will be built)
Kotzebue
King Salmon

Estimate for unmet statewide need for capital improvements.

Hospitals: Acute Care: Lorraine Derr

- Valdez Hospital in Valdez needs a new hospital; their hospital is in the end of the building where Harborview used to be. The hospital pays for utilities for the whole building and occupies just one end of it. The hospital no longer receives any state money to subsidize facility costs; they can’t afford to maintain the whole facility so they are bonding for a new hospital. They are asking for \$25 million for a new building, 29K for telemetry unit and 30K for hospital beds to replace ones that don’t work anymore.
- South Peninsula in Homer; 4.2 M replacement of emergency department, expansion of diagnostic images and support services, 1.8M to renovate ambulatory services and intensive care, 1.5M to replace medical office building. They spend about 800K a year on capital, which is typical for a facility that size.
- Cordova Community Medical Center in Cordova; 240K for a new x-ray machine, 60K for a new patient call system, 50K for patient accounting computer upgrade.
- Wrangell Hospital in Wrangell needs to remodel building 3.5 to 4M.

- Petersburg needs CT scanner and major building renovations but there are no prices yet.
- Bartlett Hospital in Juneau needs to expand, they have said that they will match 20M but they need to find the other 20M.

Hospitals: Primary Care: Rick Boyce

One good list is the list of denied applications that have been received by the Denali Commission that have not been funded because they did not fit the criteria. Dental, Mental Health and Substance Abuse services have been approved for space in village or sub-regional clinic's proposals. Stand-alone facilities in hub communities for these services have been denied in the past.

The state is updating the health facilities plan that will complete in January 2004

Nursing Homes: Lorraine Derr

The biggest need is in Seward, that facility is really old and has really special need people 3.5M would be enough to fix that problem. There is another home that needs a new boiler at 37K and another home that needs maintenance 192K.

The list of needs for hospitals includes some improvements to nursing homes that are in the same building.

Dental Services: Mary Elizabeth Rider

Cost estimated by tribal health consortium to come. There is an estimate for space standards, interior dimensions 10 X 10 or 10 X 11 maximum for a dental operatory. Ms. Rider surveyed dentists about equipment and they knew that they were getting away from x-rays and into digital and then having if possible, not portable but mobile unit. Portable unit are hauled in and out of town, mobile unit stays in town but can be put away so that space can be used for other purposes. Dentists don't like this idea so much because they will have to clean up the other person's stuff when they do get to town.

Assisted Living: Kay Branch and Patricia Atkinson

The division did determine for each level of community - what is needed and what is feasible. Also addressed other continuum of care for communities.

The work does not address or project costs for facilities – it addresses the communities which might sustain the development of an assisted living facility or other service in the continuum of elder care.

Food Banks and Pantries: Susannah Morgan

Have never done a survey.

Childcare

No answer given.

Head Start: Claudia Shanley

No answer given.

Substance Abuse: Pam Watts

Information in *An Integrated Substance Abuse Treatment Needs Assessment for Alaska*
Prepared January 2002 by North Charles Research and Planning Group.

Mental Health: Jeff Jessee

Doesn't know of any, except what DHSS is doing. Check with Arnold and ANTHC.

Domestic Violence: Susan Scudder

Estimate for unmet statewide need for capital improvements.

The council has just finished a grant process with Wells' Fargo, the Denali Commission and the Rasmuson Foundation to pay for capital improvements statewide. Through this project they have secured \$2.1 million dollars, some through the three organizations mentioned and some through the State. Other than that there are two communities that need new facilities, Emmonak and Unalaska.

Program	Location	Request
Alaska Family Resource Center	Palmer	\$534,659
Advocates for Victims of Violence, Inc.	Valdez	15,000
Abused Women's Aid in Crisis, Inc.	Anchorage	401,325
Aiding Women in Abuse and Rape Emergencies	Juneau	87,927
Arctic Women in Crisis	Barrow	86,275
Bering Sea Women's Group	Nome	46,336
Cordova Family Resource Center	Cordova	2,326
Emmonak Women's Shelter	Emmonak	10,087
Interior Alaska Center for Non-Violent Living	Fairbanks	48,340
Kenai Soldotna Women's Resource and Crisis Center	Kenai	125,962
Kodiak Women's Resource and Crisis Center	Kodiak	67,150
Maniilaq Family Crisis Center	Kotzebue	52,300
Safe and Fear-Free Environment, Inc.	Dillingham	75,650
Sitkans Against Family Violence	Sitka	67,070
SeaView Community Services	Seward	86,688
South Peninsula Women's Services	Homer	25,980
Standing Together Against Rape	Anchorage	61,402
Tundra Women's Coalition	Bethel	121,126
Unalaskans Against Sexual Assault and Family Violence	Unalaska	27,459
Women in Safe Homes	Ketchikan	157,566
TOTAL		\$2,100,628

Commitments to date:

Rasmuson Grant	\$1,000,000
Rasmuson Match	500,000
State	500,000
Denali Commission	220,000
Wells Fargo	100,000
Total	\$2,320,000

Rural Learning Centers: Bernice Joseph

Communities with identified need are:

- Saint Mary's under the Bethel Campus has secured funding to build a learning center.
- Aniak under the Bethel Campus is in need of a learning center but has not yet secured funding.
- Fort Yukon is currently \$1.8 million over-budget on the learning center project that is currently underway there. Fort Yukon has not yet secured the additional \$1.8 million necessary to complete the project.
- The Kuskokwim Campus is interested in expanding their facilities but have not yet secured funding.

There is definitely a need for additional rural learning centers but the university is carefully planning so as not to duplicate efforts. The providers of vocational and technical education are currently holding meetings on how to better coordinate and deliver services in rural Alaska. They are in the process of doing a facility need assessment and facilities plan for all the facilities in rural Alaska.

There is not currently a comprehensive estimate of need or associated cost. The Nome campus has completed assessment of their facilities and estimate a minimum cost of \$4.8 million in 2002 dollars to update their facilities.

Why is the facility type important to the delivery of health and human services?

Hospitals: Acute Care: Lorraine Derr

Hospitals are at the top of the food chain, when primary care can't handle a problem you end up in a hospital. Acute care is where you go to get it fixed.

Hospitals: Primary Care: Rick Boyce

Dental, mental health and substance abuse services all have a definite need for additional facilities at the sub-regional level. These services are usually provided at the village level from the clinic and are already included in the clinical facility costs.

Nursing Homes: Lorraine Derr

People need somewhere to go when they are no longer able to take care of themselves. Sometimes people don't need to be in hospital but need rehabilitation so they go to nursing home until they are able to get by without assistance.

Dental Services: Mary Elizabeth Rider

Dentists prefer to have operatory located where their highest number of clients will be and that is the school. If you can't have the dentist located at school, the next best place is

the health clinic. Dentists also want a place to sleep, like a bedroom; right now they are sleeping on the floors of clinics.

Assisted Living: Kay Branch and Patricia Atkinson

Addressed in the materials provided.

Food Banks and Pantries: Susannah Morgan

No answer given.

Childcare:

No answer given.

Head Start: Claudia Shanley

With the comprehensive nature of Head Start, screening, treatment and follow up of physical, oral, and mental health, it makes sense to co-locate with other health providers.

Substance Abuse: Pam Watts

It's like with any other health condition, the appropriate level of care is critical to successful outcomes, if we don't have appropriate level of care the likelihood is increased that the person may not be able to successfully address their substance abuse disorder. If a person needs an intensive level of care that is not available in the community in which they reside, and access to other places is limited due to finances, it is more likely that the condition will become an emergency. At that point treatment has to be much more intense than if the treatment had occurred earlier.

Domestic Violence: Susan Scudder

Security and safety, capacity, residential nature of services, the facility has to have kitchen and food storage, bedrooms and children's facilities as well as being ADA compliant.

Rural Learning Centers: Bernice Joseph

Facility type is important because they are learning centers; they need to have audio-conferencing capabilities, Internet access, and computers on site as well as providing a space that is out of the home. People in rural Alaska have to pay long distance charges to a service provider in order to get Internet service so it is important to provide a space where that is available. It is also important to provide a quiet space where studying and learning is supported.

of people served by facilities? Statewide and by community

Hospitals: Acute Care: Lorraine Derr

Entire population of the state since all who enter must be treated.

Hospitals: Primary Care: Rick Boyce

Unable to answer.

Nursing Homes: Lorraine Derr

Unable to answer.

Dental Services: Mary Elizabeth Rider

Can estimate by number of eligible people and days of service per village, basically assuming that everyone needs some dental care. See report.

Assisted Living: Kay Branch and Patricia Atkinson

The division does have some very rough estimates based on the number on waiver at this time but that might not be completely accurate. They are advocating for additional delineation of the numbers. Some providers don't ever put people on the waiver unless they have the option to provide services for them.

Food Banks and Pantries: Susannah Morgan

This is measured in pounds, it is difficult to get glean an accurate number of people from the pounds of food distributed.

Childcare

No answer given.

Head Start: Claudia Shanley

No answer given.

Substance Abuse: Pam Watts

The Alaska Mental Health Trust Authority funded a major project with Roy Hundorf and Diane Kaplan, they did an overview and survey and met with a large number of nonprofits and native nonprofits and developed relationships with private philanthropic organizations, both national and statewide, and worked to develop a resource list that could be used by state, health care organizations and nonprofits seeking partnership funds. Robert Wood Johnson, Rasmuson, Annie E Casey, these are all options for funding with or other than Denali Commission.

Mental Health: Jeff Jessee

DMHDD and DADA

Domestic Violence: Susan Scudder

Advocates for Victims of Violence (AVV) – 3,902 served
Emmonak Women's Shelter (EWS) – 2,559 served
South Peninsula Women's Services (SPWS) – 10,439 served
Abused Women's Aid In Crisis (AWAIC) – 53,806 served
Interior Alaska Center for Non-Violent Living (IAC) – 18,129 served
Standing Together Against Rape (STAR) – 15,492 served
Aiding Women from Abuse and Rape Emergencies (AWARE) – 40,525 served

Kenai/Soldotna Women's Resource and Crisis Center (K/SWRCC) – 50,657 served
 Tundra Women's Coalition (TWC) – 5,380 served
 Arctic Women In Crisis (AWIC) – 8,319 served
 Kodiak Women's Resource and Crisis Center (KWRCC) – 3,079 served
 Unalaskans Against Sexual Assault and Family Violence (USAFV) – 1,162 served
 Alaska Women's Resource Center (AWRC) – 3,737 served
 Safe and Fear-Free Environment (SAFE) – 33,577 served
 Victims For Justice (VFJ) – 2,936 served
 Bering Sea Women's Group (BSWG) – 14,473 served
 Sitkans Against Family Violence (SAFV) – 14,173 served
 Alaska Family Resource Center (AFRC) – 23,125 served
 Cordova Family Resource Center (CFRC) – 409 served
 Seaview Community Services (SCS) – 4,153 served
 Women In Safe Homes (WISH) – 22,743 served
 Total Served in State – 332,775

Rural Learning Centers: Bernice Joseph

Campus	# Students
Bristol Bay Campus	596
Chukchi Campus	230
Interior/Aleutians Campus	574
Kuskokwim Campus	366
Northwest Campus	476
Rural College Campus	904
Tanana Valley Campus (Fairbanks)	2,474
TOTAL	5,018
Total without Tanana Valley Campus	2,842

of people needing services but unserved? Statewide and by community

Hospitals: Acute Care: Larraine Derr

Unable to answer

Hospitals: Primary Care: Rick Boyce

Unable to answer

Nursing Homes: Larraine Derr

No answer given.

Dental Services: Mary Elizabeth Rider

All adults without private dental coverage.

Assisted Living: Kay Branch and Patricia Atkinson

ANTHC has received a long-term grant from the IHS for a comprehensive assessment of native care needs of the Alaska Native Population. That should help provide more definition of the numbers of Alaska Elders in need.

Food Banks and Pantries: Susannah Morgan

Poverty rates.

Childcare

No answer given.

Head Start: Claudia Shanley

This information should be gathered in the assessment that is planned for the future.

Substance Abuse: Pam Watts

No answer given.

Mental Health: Jeff Jessee

DMHDD and DADA

Domestic Violence: Susan Scudder

In process of planning to do needs assessment. However the methods used to determine unmet need are not reliable seeming. There are a lot of national statistics regarding domestic violence and sexual assault but sources are unclear.

Rural Learning Centers: Bernice Joseph

There are no good numbers to indicate numbers unserved.

Are there options for capital funding other than the Denali Commission?

Hospitals: Acute Care: Lorraine Derr

There are funding sources other than the Denali Commission in the larger communities and not very many in the smaller communities. There is bonding in some cities, but in other communities like Wrangell and Petersburg there is no money left in the town. In Juneau they passed a bond issue, when you get to the cities there is some money this is possible, but not in little places other than Fairbanks, Anchorage and Juneau.

Hospitals: Primary Care: Rick Boyce

There are other funding options, the Mental Health Trust, CDBG, IHS has several programs and will have new prioritization methodology for facility construction in the

next few years, tribal organizations use self generated revenue for third party resources, etc., Rasmuson foundation, CDBG.

Nursing Homes: Lorraine Derr

In the larger cities yes, in smaller places no. In Seward, Providence helps out financially. It is in the really small places that they have city owned health facilities with major problems. Dillingham and Bethel have federal funds for capital projects but still need someone to cover operating expenses.

Dental Services: Mary Elizabeth Rider

Yes, Section 330 Community Health Center money. That funding was expanded this year, Indian Health Service also has some money that overlaps.

Assisted Living: Kay Branch and Patricia Atkinson

Yes the division has prepared information for communities on this - pre development 30 sources – 10 sources have been actively used by organizations in Alaska.

Food Banks and Pantries: Susannah Morgan

Rasmuson Foundation, State of Alaska DCED, just beginning discussions with USDA.

Childcare

There is one example of a facility receiving HUD matching funds.

Head Start: Claudia Shanley

There is a small pot of money from the state general fund (\$200,000) for health and safety. There is a potential for grantees to request federal money.

Substance Abuse: Pam Watts

The Alaska Mental Health Trust Authority funded a major project with Roy Hundorf and Diane Kaplan, they did an overview and survey and met with a large number of nonprofits and native nonprofits and developed relationships with private philanthropic organizations, both national and statewide, and worked to develop a resource list that could be used by state, health care organizations and nonprofits seeking partnership funds. Robert Wood Johnson, Rasmuson, Annie E Casey, these are all options for funding with or other than Denali Commission.

Mental Health: Jeff Jessee

USDA, private foundations (Rasmuson, Murdoch, etc.), AHFC and HUD.

Domestic Violence: Susan Scudder

- Rasmuson,
- State of Alaska (1st time in more than 15 yrs),
- Wells Fargo,
- individual local donors and
- a lot of in-kind services that are done.

Rural Learning Centers: Bernice Joseph

- State Appropriations
- HUD
- US Department of Education Title III
- AHFC and Banks
- Federal Set-Asides

Are there project prioritization methodologies currently in place?

Hospitals: Acute Care: Lorraine Derr

Yes there are in each hospital. These methodologies are the responsibility of the hospital administrator in each hospital.

Hospitals: Primary Care: Rick Boyce

IHS has a method for several categories of facilities and is developing a new prioritization methodology.

Recommendations for prioritizing funding: Overall emphasis should be consistent with the desire to provide health care as close to patient as possible. Need to balance this with sustainability of services? Prioritize on rural requirements and areas where the private sector cannot or does not meet the need. Mental Health, Substance Abuse and Dental all appear to be clear and immediate needs. May prioritize initially to hub locations to begin to meet the needs most effectively.

Nursing Homes: Lorraine Derr

Yes and no, it depends on each specific place.

Dental Services: Mary Elizabeth Rider

Not yet, but they are about to set some.

Ms. Rider recommended prioritizing according to economic sustainability, dental need and readiness. A community can have high dental need and a dentist ready and able to come and then have no place to put the dentist. The community needs to be ready to and know how to build a facility to house the dentist.

Assisted Living: Kay Branch and Patricia Atkinson

Developed a list of community priority – level III communities that are hospital base without long term care (nursing home) resources – Bethel

Community without assisted living resources – Nome, Valdez, Cordova, and Petersburg and Wrangell- (communities have different capacity to provide full continuum – some communities are supporting out of home options that will diminish the need for assisted care.

Food Banks and Pantries: Susannah Morgan

No

Childcare

No

Head Start: Claudia Shanley

The planned assessment will get some information on this.

Substance Abuse: Pam Watts

That kind of a process does occur but Ms. Watts does not know if it is structured. Some years back there was a statewide needs assessment done for all facilities to assess capital needs but there has not been another assessment done since then.

Mental Health: Jeff Jessee

USDA might have something.

ANHA – Wants to do a statewide housing survey, but can't get the partners they need.

DHSS – has a list of communities that they were going to do architectural surveys

Domestic Violence: Susan Scudder

There are no methodologies in place officially, but if they were to prioritize it would be based on safety needs. With the capital improvements project happening now, Rasmuson hired someone to go through all shelters to look at what was needed. For the most part everyone got what they wanted.

Rural Learning Centers: Bernice Joseph

Yes, a big part of that is first doing the facilities assessments and plans. After facilities plans are done. the directors will sit down and prioritize projects according to greatest need. The projects will then have to be sent through the chancellor's cabinet to become part the universities master plan.

If new facilities are funded, are there funds available to maintain the facility? Is there funding to support program services?

Hospitals: Acute Care: Lorraine Derr

Yes, they are operating now and monies are available. They are not planning to build any new hospitals.

Hospitals: Primary Care: Rick Boyce

Sustained IHS, village built clinic lease money, M&I funds section 330, and third party billing and M & M as well as state grant funds.

Nursing Homes: Larraine Derr

Medicaid funds, its hard for private pay people to exist in nursing homes because they are so expensive but sometimes they do. As long as Nursing homes stay full they are financially ok. In small communities if just a couple people die they are hurting. If a facility has 10 beds and 4 residents die then that cuts out 40% o revenue. Some nursing homes have waitlists, but some don't.

Dental Services: Mary Elizabeth Rider

Yes, if there is a sufficiently large number of children on Medicaid or residents who have third party payers, or a sufficiently large number of IHS beneficiaries. However, even if the billable population is low in numbers, there can still be sufficient funding if their children's dental health is extremely poor. For example, a large community can have good children's dental health and therefore require services that are frequent but billable at lower amounts. A small community can have very poor dental health among its children, and still be able to support a facility because the level of dental care needed is much higher and billable at higher rates.

Assisted Living: Kay Branch and Patricia Atkinson

Most assisted living homes rely on the Medicaid waiver patients - five or six assisted living homes in rural areas including:

- Tanana- State subsidies
- Barrow- mostly NSB resources
- Kotzebue- state subsidies
- Dillingham – waivers
- Kodiak – just opened in June don't know revenue sources

Statewide the waiver pays for half of the beds - Waiver only pays for services, not room and board.

Food Banks and Pantries: Susannah Morgan

There is some money, they are just beginning to attract outside funds
Native children's federal funds, they need expertise to get the federal funding.

Childcare

Fees for service/tuition. Limited funds from the state to address health and safety needs. Small amount from child-care grants is available for training, there are also food programs and childcare assistance.

Head Start: Claudia Shanley

No

Substance Abuse: Pam Watts

An increase to the alcohol excise tax went into effect last October; half of the receipts from that tax were to be directed toward alcohol prevention and treatment programs. Supporters of the tax increase effort have put together a package of recommendations for the new administration; this document is not yet available to the public but will be

coming out very shortly. That document could be a foundation for continued support for programs but it is not limited to treatment programs, there may be pieces in there regarding juvenile justice and services to rural Alaska.

Mental Health: Jeff Jessee

In some cases, yes. In mental health, you can use Medicaid to fund program services. For places where there is deferred maintenance, there will be existing program funding sources. New facilities, program money for program services in some cases. Maintenance should be incorporated in client fees, but often it is not.

Domestic Violence: Susan Scudder

There is definitely funding to support program services, it is happening now. Local funding sources would kick in for maintenance of new facilities. The services for domestic violence and sexual assault are very well supported in all the communities where they are located. Local funding sources include; city, municipal government, tribes, united way, local individual contributions, volunteer time, and in-kind work.

Rural Learning Centers: Bernice Joseph

Funding is mainly through Fairbanks Native Association (FNA) indirect funds. They of course get a base out of the General Fund (GF) and then the FNA indirect funds fill in the gaps. Additionally, rural campuses have done a great job of bringing in grants on their own. They are all minority-serving institutions so they are eligible for federal set-asides from NSF, HUD, USDA and others they have not yet tapped into such as NOAA and NASA.

Are there other programs providing services like yours?

Hospitals: Acute Care: Lorraine Derr

No

Hospitals: Primary Care: Rick Boyce

No answer given.

Nursing Homes: Lorraine Derr

Not directly, there are services provided by the state to allow you to stay at home for as long as possible. These in-home programs exist in smaller communities but are not as readily available. I think the in-home services are adequate right now but it depends how they decide to restructure senior services. There are people who believe that elders should exist at home for as long as possible and there are some who do not. That is a philosophical discussion.

Dental Services: Mary Elizabeth Rider

No, there is a new dental health aide program coming up but not in place now, they are currently developing standards and billing mechanisms.

Assisted Living: Kay Branch and Patricia Atkinson

No answer given.

Food Banks and Pantries: Susannah Morgan

Salvation Army in Cordova, Mother Lawrence in Anchorage, Food Stamps, WIC, School lunch and nutrition.

Childcare

Head Start

Head Start: Claudia Shanley

No

Substance Abuse: Pam Watts

Not directly applicable since they are a planning organization more than a service provider. They plan and advocate for addressing the negative consequences of alcohol in the state, they are one of four advising and planning boards under AMHTA.

Should also know that DHSS initiated a substance abuse mental health integration committee with a primary goal of discussing the benefits and methods of enhancing service delivery for rural Alaska where treatments are offered by one person or one program. The committee addressed the issue of people with co-occurring disorders; they want to work toward a philosophy of "no wrong door", one stop shop screening and possibly even some initial level treatment. This goes back to the national focus on integrating primary care with substance abuse.

The Denali commission could be on the cutting edge of that movement and Alaska could be a model for others.

Mental Health: Jeff Jessee

No answer given.

Domestic Violence: Susan Scudder

There are two shelter facilities, one in Kotzebue, funded by the regional Native corporation (this one they provide capital funds but not operating), and one in Anchorage that exclusively serves Native women, Willa's Way, they are federally funded 100%.

Rural Learning Centers: Bernice Joseph

The cooperative extension offers access to computers and the Internet as well as some career and education advising, they do not offer a classroom setting. The cooperative extension has offices in the following 12 communities in Alaska:

Anchorage	Fairbanks	Palmer
Bethel	Juneau	Sitka
Delta Junction	Kodiak	Soldotna/Kenai
Eielson Air Force Base	Nome	Thorne Bay

There are also Native nonprofit that provide learning centers. These learning centers more often offer adult education programs like GED training and career skills. There are no other organizations that offer degree programs or classroom settings.

Are there other programs that you can (or do) partner with in delivering services?

Hospitals: Acute Care: Lorraine Derr

Smaller hospitals partner with larger hospitals, i.e. Valdez and Cordova hospitals partner with Providence in Anchorage for cases they cannot handle. The hospital in Juneau partners with facilities in Seattle.

Hospitals: Primary Care: Rick Boyce

No answer given.

Nursing Homes: Lorraine Derr

Not really. Don't have outside people coming in to nursing homes.

Dental Services: Mary Elizabeth Rider

Dental health aide program and dental hygiene.

Assisted Living: Kay Branch and Patricia Atkinson

No answer given.

Food Banks and Pantries: Susannah Morgan

In the future: Domestic violence shelters, general social services shelters and health centers.

Childcare

Public Health Nurses, Head Starts and larger employers providing childcare for employees.

Head Start: Claudia Shanley

Yes, there are some childcare providers, independent learning programs when appropriate that are possible with school funded early childhood programs.

Substance Abuse: Pam Watts

Division of Alcohol and Drug Addiction, so many services are private. What they do is Department of Corrections contracts with treatment providers to come in and provide services in their facilities. Ask Loren that question. The board partners with all sorts of people. There is a lot of partnering with Native nonprofits.

Mental Health: Jeff Jessee

Primary care and behavioral health, public health nursing
Galena model – health clinic, behavioral health, city offices and community center in one building. There are opportunities with public safety too.

Some communities are moving towards a community response approach, there are plans for responding to emergencies and co-location helps facilitate that.

Domestic Violence: Susan Scudder

Partner with variety of other state agencies to make sure there is community response and support for victims, partner with prosecutors, courts, tribes and local and state law enforcement.

Rural Learning Centers: Bernice Joseph

The college of Rural Alaska is interested and actively pursues partnership with any organization that operates in rural Alaska. Partnerships provide opportunities for cost sharing, information sharing and workforce development. Rural campuses are there to meet the needs of the community in which they operate. They achieve this goal by offering degree programs, career and workforce development, as well as special topic courses by request.

Native nonprofits are key partners in terms of co-sponsoring courses and providing some learning center facilities. They are also partners in offering some courses, such as medical billing and nursing. The Yukon-Kuskokwim Health Corporation provides space and expertise in offering courses in the health care profession.

Other examples of community partnership include:

- Community Development Quota (CDQ) programs offer scholarships and internships.
- In Galena the rural learning center is co-located with the charter school.
- In Togiak the learning center is co-located with the Youth Opportunity Program, which is funded by the Alaska Federation of Natives.
- In King Salmon the rural learning center is located in city office space.

Are there other programs that you can (or do) co-locate your services with?

Hospitals: Acute Care: Lorraine Derr

In small towns clinics are located in hospitals, Wrangell and Petersburg, there are also pharmacies in many hospitals. Some hospitals in smaller communities have some social services programs and community programs on site.

Hospitals: Primary Care: Rick Boyce

No answer given.

Nursing Homes: Lorraine Derr

Hospitals

Dental Services: Mary Elizabeth Rider

Schools and then clinics.

Assisted Living: Kay Branch and Patricia Atkinson

No answer given.

Food Banks and Pantries: Susannah Morgan

No answer given.

Childcare

Church Sunday school space, community centers and sometimes space in senior center in late afternoons for after school care. Larger employers.

Head Start: Claudia Shanley

Bristol Bay is finalizing a facility that includes district, independent learning centers, the Division of Family and Youth Services as well as Head Start.

Substance Abuse: Pam Watts

Yes, because there is such a scarcity of facilities (In Dillingham there is no residential substance abuse treatment program for women with children so they stay at women's shelter and receive treatment from other substance abuse providers).

Partners not only save money but also bring together service providers that should work on the same person; this enhances services delivery and expands access to support services. One small community thought to maybe try to utilize some BLM buildings that were empty by putting transitional housing and treatment facilities in same complex. Another of the building would be used as transitional supported housing for adolescents who were either returning from treatment or institutions who could not return to their own homes.

Mental Health: Jeff Jessee

No answer given.

Domestic Violence: Susan Scudder

In some places yes, in Seward the services are part of Seaview community services but they do not provide residential shelter services. AWRC provides drug and alcohol counseling services as well as domestic violence and sexual assault services; they also do not provide residential shelter services.

Rural Learning Centers: Bernice Joseph

In Galena they are co-located with the charter school, in Togiak with the Youth Opportunity Program funded by AFN, in King Salmon they are in city office space. It would be a good idea to co-locate with tribal government entities because they do so much staff training and possibly more co-locating with school districts.

Are there other programs that you can (or do) cost-share with?

Hospitals: Acute Care: Lorraine Derr

This gets real tricky because of Medicaid

Hospitals: Primary Care: Rick Boyce

No answer.

Nursing Homes: Lorraine Derr

Hospitals

Dental Services: Mary Elizabeth Rider

Almost every single dentist working in villages are not in private practice they are in public practice. If a dentist is serving a village they are doing it either through a native hospital or IHS. There are two or three dentists that are private practice and are sub-contracted by city government that go into villages and provide services.

Assisted Living: Kay Branch and Patricia Atkinson

No answer given.

Food Banks and Pantries: Susannah Morgan

No answer given.

Childcare

Church Sunday school space, community centers and sometimes using space of senior center in late afternoons for after school care. Larger employers.

Head Start: Claudia Shanley

Head Start is a broker of services and relies on others to provide services such as Denali Kid Care. Good questions. Hopefully the assessment will help.

Substance Abuse: Pam Watts

This is almost same answer as above, with the one example from Dillingham there is some cost sharing for providing services to the children of women who might have substance problems and be victims of domestic abuse.

Providers are required to do medical screening of all new clients, they are mostly screening questions but if a person comes in who has not been screened they may be referred to a doctor which is sometimes a problem because often times people don't have enough money to go to doctor. There is a natural partnership between primary care and chemical dependency and mental health treatment. Ms. Watts strongly supports the Denali Commission integrating primary care with behavioral health and mental health.

Mental Health: Jeff Jessee

If you co-locate, it's cheaper to run one building (especially utilities). Where you run into problems is if you over build the space. Can also save money with shared computer systems, clerical, billing, etc.

Domestic Violence: Susan Scudder

In examples of co-location there are rent cost sharing that occurs.

Rural Learning Centers: Bernice Joseph

Native nonprofits, health corporations, some vocational education centers, CDQ's etc.

Additional Comments:

Hospitals: Acute Care: Lorraine Derr

The crux of the problem is in smaller places where primary care and hospital care are in the same place. The Denali Commission will look at places with hospitals and say that primary care is already available, but if hospitals are not in good working condition then primary care has to look elsewhere. Out on the Aleutian chain is one example of this problem. When primary care can no longer handle a case they go to Kodiak, if the Kodiak hospital can't handle the case because the hospital isn't working well then they have to send people along to Anchorage. It would be better to recognize that even when a place has a hospital they are not always able to provide primary care due to lack of quality facilities.

Wrangell's nursing home supports the hospital there; right now they are taking in about 400K a month, and it is costing them about 480K a month to operate. There is no money in Wrangell so the director has already laid off 8 people and the doctors go next. Making sure that infrastructure is maintained is something the Denali Commission should be doing.

Nursing Homes: Lorraine Derr

Nursing homes are a little different animal than hospitals; you don't need doctors you just need to have RN's on duty. It is good to be close to hospital but not necessary.

Assisted Living: Kay Branch and Patricia Atkinson

Statewide need – more info is needed on actual numbers needing care.
Cost of providing

Dental Services: Mary Elizabeth Rider

Funding to support dental operatories may be strengthened if the state of Alaska expands adult dental care beyond the current level, which is emergency care only.

KEY INFORMANT INTERVIEWS

Facility Type	Organization	Contact Name	Contact Info
Hospitals: Acute Care	ASHNHA	Lorraine Derr	907-586-1790
Hospitals: Primary Care	Alaska Native Tribal Health Consortium	Rick Boyce	907-729-3601
Nursing Homes	ASHNHA	Lorraine Derr	907-586-1790
Assisted Living	Rural Programs	Kay Branch	907-269-3666
Assisted Living	Rural Assisted living Development	Patricia Atkinson	907-269-3639
Food Banks	Food Bank of Alaska	Susannah Morgan	907-272-3663
Food Pantries	Food Bank of Alaska	Susannah Morgan	907-272-3663
Childcare	NAEYC Northern Regional Office	Claudia Essley,	907-451-3192
Childcare	NAEYC Southeast Regional Office	Joy Lyon	907-789-1235
Childcare	NAEYC Southwest Regional Office	Michelle Jaeger	907-563-2998
Head Start	EED	Claudia Shanley	907-269-4518
Head Start	NAEYC-SEA	Joy Lyon	907-789-1235
Head Start	Fairbanks North Star Borough	Cheryl Keepers	907-459-1474
Substance Abuse	ABADA	Pam Watts	907-465-8920
Mental Health	AMHTA	Jeff Jessee	907-269-7960
Domestic Violence	Council on Domestic Violence and Sexual Assault	Susan Scudder	907-465-5504
Environmental Health and Facilities	Indian Health Service	Tom Cooldige	907-729-3501
Primary Care	Alaska Primary care Association	Marilyn Kasmar	907-465-8618
DHSS	Division of Public Health	Karen Pearson	907-4653090
Funding	Rasmuson Foundation	George Hieronymus	907-297-2700

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Internet links:

Department of Health and Social Service: Division of Administration: Certificate of Need

<http://www.hss.state.ak.us/das/facilities/certofneed/>

Department of Education and Early Development

<http://www.eed.state.ak.us/EarlyDev/licensing.html>

Food Bank of Alaska

<http://www.foodbankofalaska.org/>

Department of Education and Early Development

<http://www.eed.state.ak.us/earlydev/childcarecenters.pdf>

Denali Commission

<http://steller.denali.gov/dcpdb/index.cfm?action=dsp&type=reports>

Division of Senior Services

<http://www.state.ak.us/admin/dss/rural/>

A-DHSS DEFINITIONS OF COMMUNITY LEVEL OF CARE
EMS Community Levels of Care

Level	Level Definition	Population	EMS	General Access
1	Isolated Villages	Usually 50-1,000 in immediate community	Community clinic with a CHA or EMT	Limited air or marine highway access to a Level III or higher community; road access exceeds 60 miles.
1	Highway Villages	Usually 50-1,000 in immediate community	Community clinic with a CHA or EMT	Limited air or marine highway access to a Level III or higher community; year-round, 60 minute or less road access.
2	Isolated Towns or Sub-Regional Centers	Usually 500-3,000+ in immediate community	Community clinic with a PA, NP, MD or DO; health care services provided by public or private sector.	Marine highway or daily air access to closest Level III or higher community; air service to Level I communities in area.
2	Highway Towns or Sub-Regional Centers	Usually 500-3,000+ in immediate community	Community clinic with a PA, NP, MD or DO; health care services provided by public or private sector.	Marine highway or daily air access to closest Level III or higher community; year-round, 60 minute or less road access.
3	Large Towns or Regional Centers	Usually 2,000-10,000+ in immediate community, providing services to a regional population.	Community hospital and physicians; health care service agencies include both public and private	Daily airline service to Level III, IV & V communities; air service to Level I & II communities in area; road or marine highway access all year.
4	Small Cities	Usually 10,000-100,000 in immediate community, providing services to a larger regional population.	Hospitals with a 24 hour staffed ED and full continuum of care; multiple providers of health care and other services including both public and private programs.	Daily airline service to Level II, III, IV & V communities; road or marine highway access all year.
5	Urban Centers			
* Taken from Alaska EMS Goals "A Guide For Developing Alaska's Emergency Medical Services System" Revised February 1996				